TO BE COMPLETED BY FUNERAL DIRECTOR

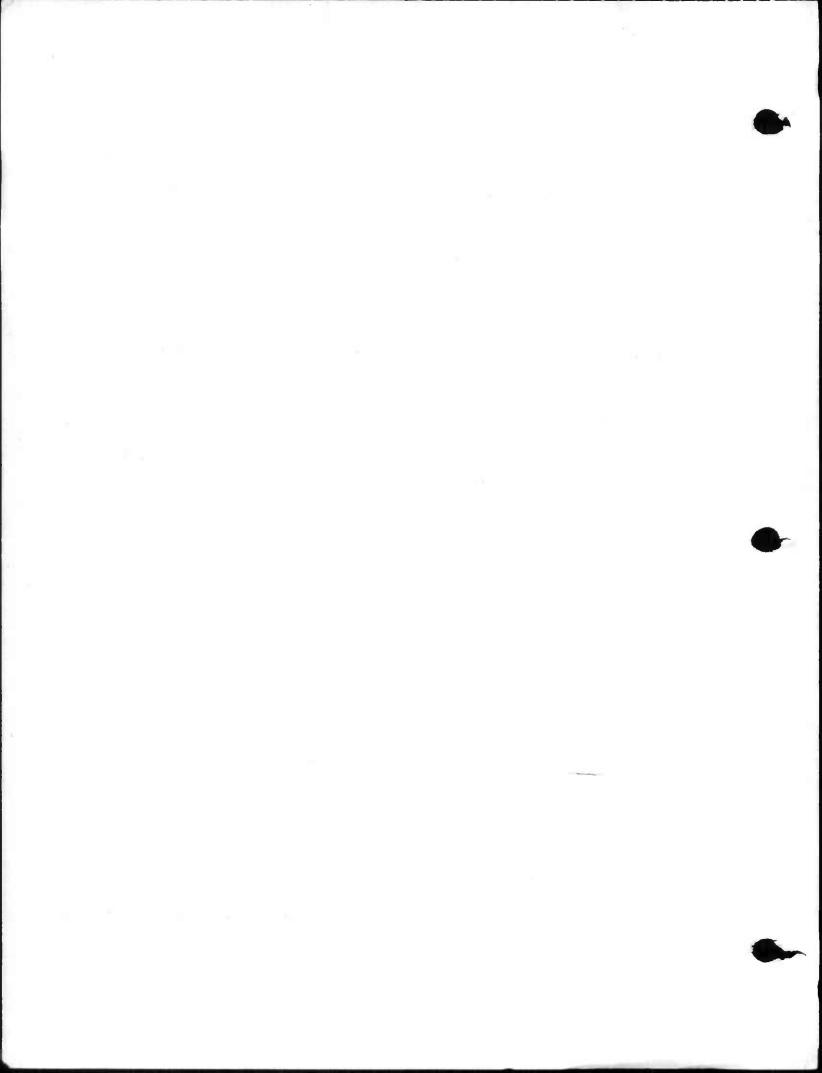
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR

1 - STATE REGISTRAR		SIMIE UF I	CI	ERTIF	ICATE (MENIAL F	REG. NO.	E			
1. DECEDENT'S NAME (First,	, Middle, Last)							2. DATE OF	DEATH DA			3. TIME OF DEATH	
EDWARD						NOV	23	199	YEAR D	3:08 PM			
4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (in yrs. las	t birthday)	IF UNDER 1 Y		INDER 24 HRS.	7. DATE OF	BIRTH			PLACE (Stata or Foreign	
578-78-4407	36	YRS,	MONTHS D	AYS HOU	JRS MIN.	May 17, 19		958		h Carolina			
9a. FACILITY NAME (If not in			9b. CITY, TO	WN OR LO	CATION OF DE		,		INTY OF DE				
6213 SPRINGHILL CT GREENBELT										DDT	NCE	GEORGES	
RESIDENCE OF DEC	EDENT						U 1.			LIVI	IVCE	GEORGES	
10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									tod. INSIDE CITY LIMITS?				
									1 XXVES 2 NO				
2110 East Marlboro Avenue, #11 20785 U.S.A									HAT COUNTRY?				
1 Never Merried 2 Married FORCES? 1 YES 2 NO If yes, specify Cuban, Maxican, Puerto Rican, atc.)							Black.	RACE — American Indian, Black, Whita, atc. Specify: Black					
	EDENT'S EDUC		tea, DE	CEDENT'S	USUAL OCCU	IPATION	vorkina	tsb. Kii	ND OF BUS	SINESS/IN	DUSTRY		
Elementary/Secondary (0)-12)	College (1-4 or 5			work done during se retired.)				Dr	ivate			
12th grade			30	ore	Clerk				ri.	Lvace	=		
17. FATHER'S NAME (First, M	liddle, Last)					1		ME (First, Midd		Sumame)			
Randolph La		er, SR.						Thorn					
tillie Land								Route Number,		,		D 20785	
20a. METHOD OF DISPOSITE	ION	wel from State			OF DISPOSITIO	ON (Name of		DATE	20c. LO	CATION —	City or Tox	wn, State	
4 Donation 5 Other	(Specify)		- HArmon	y Me	morial	L PAr	k 11	1/29/9	La	andov	ver,	MD	
21, SIGNATURE OF FUNERA	L SERVICE LICI	ENSEE	1	. , 1	22. NA1	ME AND AD	DRESS OF FA	oury Tunera	1 Hor	20			
Mai	vanu	X X.	DU	Xto	Y 7474	4 Lan	dover	Rd.	Lando	over		20785	
23. PART I. Enter the d	iseesee, Dr c	omplications the	t caused the de	eth. Do r	not enter the	e mode o	f dying, suc	h ae cerdiec	Dr reepl	ratory ar	rreet,	Approximate Intervei Between	
IMMEDIATE CAUSE (Fir disease or condition resulting in deeth)	nei	SICKE	CELL DIS	EASE								Onset and Death	
if sny, leading to imme- cause. Enter UNDERLY	Sequentielly list conditione, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
PART ii. Other significe	ont conditions	contributing to	death but not i	reeulting	in the under	riying csu	use given in	1	a. WAS AN	IMED?	24b.	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE	
							_	' '	YES 2	□ NO		OF DEATH?	
DID TOBACCO U	ISE CONTR	IBLITE TO CA	LISE OF DEA	TH VI	S D NC		INCERTAII					t YES 2 NO	
25. WAS CASE REFERRED TO		IDOIL TO CA			TH (Check only		TACERIAII						
EXAMINER?		HOSPITAL:			OTHER:		Tab-eld-ee-	a - 01 - 10					
27. MANNER OF OEATH		28a. DATE OF	INJURY	28b. TIM	E OF 28	c. INJURY		8 Other (S		NJURY OC	CURED		
1/ Natural S	- Inding	(Month, E	Day, Year)	IN.	JURY	WORK?	2 NO						
2 Culate	Investigation Could not be	28a. PLACE (F INJURY — At he	me, ferm,	atreet, factory,	office		281, LOCATIO	ON (Street a	and Numbe	er or Rural R	loute Number,	
	datarminad	building	atc. (Specify)					City or 7	own, State)				
		CIAN: To the best of) and manner as stated.	
296 SIGNATURE AND TITLE	офсентици	0 . 0				29c.	LICENSE NUI	MBER		29d. DA	TE SIGNED	(Month, Day, Year)	
Mulgures	noser	fault	1				CME			▶N(OV 2	4,1994	
NAME AND ADDRESS OF	PERSON WHO	CORPLETED CAU						altimo	ore,	Ma	ryla	nd 21201	
31. DATE FILED (Month, Day, NOV 2	8 1994	32. REGISTRA	AR'S SIGNATURE				-						

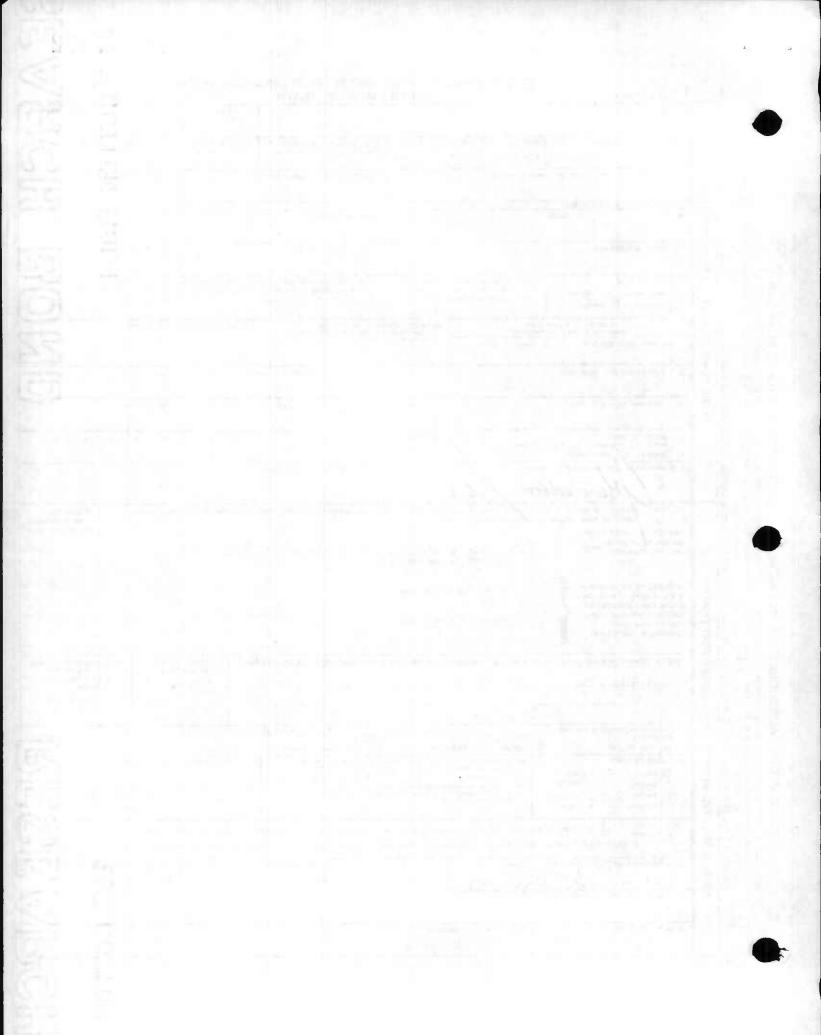




LOR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within yours after death. Page 6 may be retained by the hospital or attending physicial
ours after
II.
ificate be executed w.
recrificate be executed w.
The law requires that the death certificate be executed w
JAN: The law requires that the death certificate be executed wi

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	s marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The	TO THE FUNERAL DIRECTOR: After this certificate ha	be filed within 72 hours after death with the State D	IMPORTANT: If Item 28 is marked, or Item 3

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM			MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Las ARTHUR FF	RANCIS LATCHFO	ORD			2. DATE OF DEATH	A GYEAR	3. TIME OF DEATH M M	
	4. SOCIAL SECURITY NUMBER 215-01-1536 8a. FACILITY NAME (If not institution, give	35 d 4 2 □ F 83	3 YRS.	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN. PR LOCATION OF DE		Cou	THPLACE (State or Foreign arry Land	
TOR	3378-E North Cha	· · · · · · · · · · · · · · · · · · ·			icott Cit		Howard County		
DIRECTOR	100. STATE 10b. COUNTY Maryland Howa		OWN OR LOCAL				10d. INSIDE CITY LIMITS? 1 ☐ YES 2:\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		
FUNERAL	10. STREET AND NUMBER 3378-E North Chat	ham Road	201	101	21043		10g. CITIZEN OF	WHAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 Married TMdowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 TYES, GIVE WAR OR D	2 NO	If yes, sp	ENDENT OF HISPAN	IC ORIGIN? (Specify Year, Puarto Rican, etc.)	or No — 14. RA	CE — American Indian, ack, White, atc.	
COMPLETED	1s. DECEDENT'S ET (Specify only highest gra Elementary/Secondary (0-12)	de completed) College (1-4 or 5+)	16a. DECEDENT'S US (Give kind of work life. Do NOT use in ACIENT	done during mo	DN st of working	Railroa	SINESS/INDUSTRY	W 72	
	17. FATHER'S NAME (First, Middle, Last)		- 100-0-10-0	ME (First, Middle, Malden	Sumame)				
BE	John A. La	itchford	19b. MAILING AD	DRESS (Street a		Magdaline Noute Number, City or Tow			
9	Mr. Harry Wilhel	m				Arlington,		1.3	
	20a. METHOD OF DISPOSITION 文文 野流rial 2 Commation 3 日 Ra 4 Donation 6 D Other (Specify)	moval from State	netery, cremetory or other Columbia G	plece!			CATION — City or		
	21. SIGNATURE OF PUREHAL SERVICE	LICENSEE	M00535	Sla	o address of fac ok Funera	to the same of the			
	IMMEDIATE CAUSE (Final	b. List only one cause on e	d the deeth. Do not each line.	enter the mo	de of dying, sucl	n es cerdiac or reep	ratory srreat,	Approximata interval Between Onset and Daath	
	disease of condition								
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING								
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST OUE TO (OR AS A CONSEQUENCE OF):								
A	PEDECORNED?							4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
PHYSICIAN: MEDIC	1 YES 2 NO OF								
SIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				ACE OF DEATH (Chi	nck only one)			
IYSIC	1 YES 2 □ NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpatient 2 ER/Outp	patient 3 DOA 4		5 Residence			Company of the Compan	
ВУ	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b	(Month, Day, Year)	Y — At home, farm, stre	M 1 🗆	RK? /ES 2 NO	281. LOCATION (Street City or Town, State)	and Number or Run	ni Route Number,	
LETE	4 Homicide datermined								
COMPLETED	(Check only one) 20 MEDICAL EXAMI	SICIAN: To the best of my know NER: On the basis of examination						e(a) and menner as stated.	
TO BE	30. NAME AND ADDRESS OF PERSON V	Typ. ms	1. 1	A.E.	D317		29d, DATE SIGN	ED (Month, Day, Year)	
	456 THEMWCIC	CONE WAY	Ellia		y mo	21042			
	DEC 0 1 1994	32. REGISTRAR'S SIGN	ATURE						



use as the burial-transit permit. Pages 1, 2, 3 should

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attending physician

signed by the atter Health and Mental

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DIRECTOR: After the hours after death was

TO THE HOSPITAL OR AT
TO THE FUNERAL DIRECT
be filed within 72 hours a
IMPORTANT: If Item 2

2

Hygiene prior

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requires that the death certificate be

HOSPITAL OR ATTENDING PHYSICIAN: The law

removal. medicai filled in by

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item ! certificate the the State

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CERTIFICATION

MEDICAL shows any

PHYSICIAN:

BY

COMPLETED

BE

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FUNERAL DIRECTOR

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ST FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF CEATH 1400 TOWARD 94 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 1)X M 2 | F 39 -2106 MONTHS DAYS HOURS MIN PARYLAND YRS. luly 9a. FACILITY NAME (If not institution, give street and number) 3 50 1 5. HAND IST 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH HARBOR VIEW STREET HUSPITAL BAUTIMORE CITY 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE CITY. MARYLAND 1 YES 2 NO 100, STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? VIOLET AVE 21211 U.S.A 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuben, Maxican, Puerto Rican, atc.)
1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 14. RACE — American Indien, Black, White, etc. FORCES? 1 YES 2 1 Never Married 2 Married Specify: RLACK 3 Widowed 4 Divorced 15. OECEDENT'S EOUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) CONSPUCTION DRY WALL ENSTALLATION 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME TFirst Middle Maiden Surname ELLIVOP EUGENE LEE ANNA MAE COSTLEY 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) STREAMER RD HERMAN FILMURE COSTLEY SUKESVILLE MD Z1784 200. METHOD OF DISPOSITION 20b. PLACEAND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 Burlai 2 Cremation 3 Removal from State Crematory or other place! 4 ☐ Donation 5 ☐ Other (Specify) 4PMPSTEAD MD, 21074 21. SIGNATURE OF THE RAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 91 WILL 15 55 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, WESTMINSTER, MD. Approximata ahock, or heert fallure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition_ Candidrespiratom resulting in death) DUE TO (OR AS A CONSEQUENCE OF) nightlopath One month Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING (9 CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in deeth) LAST PART II. Other algorificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO DF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 TES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 28a. DATE OF INJURY 27. MANNER OF CEATN 28c, INJURY AT WORK? 28b. TIME OF 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation 1 YES 2 NO Accident 28e. PLACE OF INJURY — At home, term, street, lectory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide 29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the ilme, date and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of axamination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) and manner ea stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. OATE SIGNED (Month, Day, Year)

chun M.D 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

Chuu 1. out 300 Wen-min S. Hanover 31. Die File Jahren Julia die Alegarita Aleutiune

11/29/94

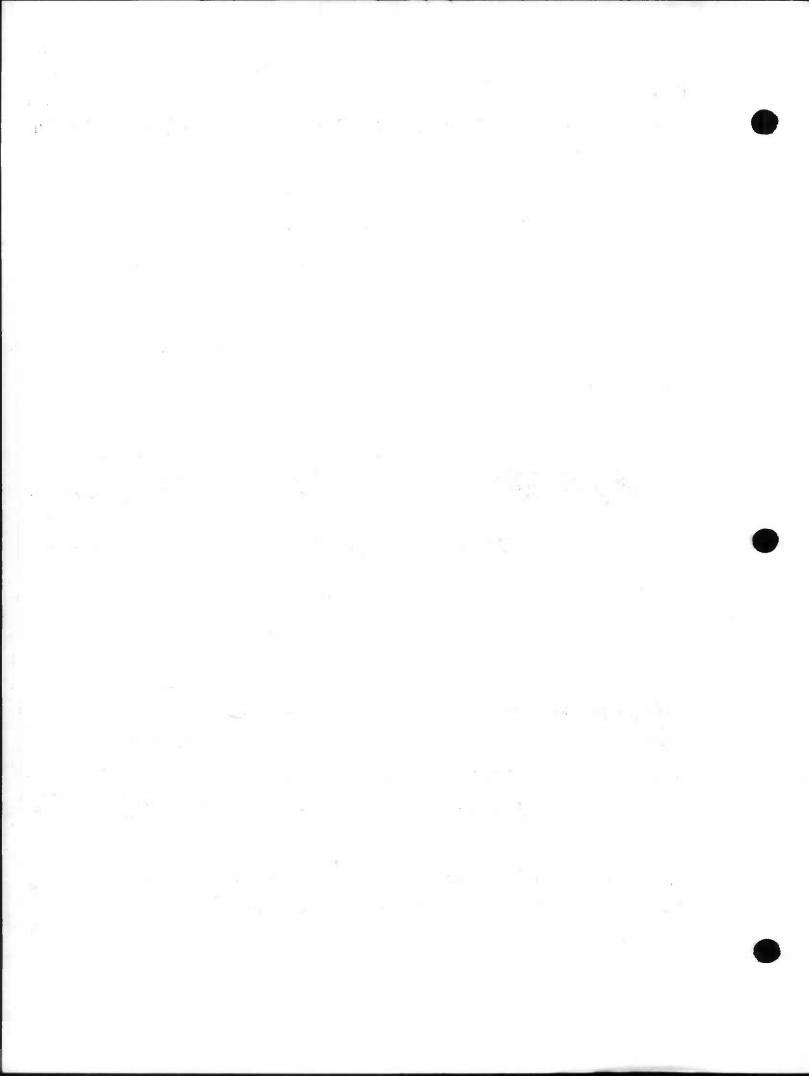
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		1 - FOR STATE OF MARYLAND / DEPA CERTIFICATION CERTIFICATI	RTMENT OF HEALTH AND MENTAL HYGIENE FICATE OF DEATH REG. NO.										
			YTON 2. DATE OF DEATH MONTH DAY YEAR 00 4	5 A.M									
P	í	4. SOCIAL SECURITY NUMBER 229-28-8601 5. SEX 1 M 2 X F 26 YRS.	MONTHS DAYS HOURS MIN. Feb. 23, 1968 Virgini	Foreign La									
, 2, 3 should	TOR	9a. FACILITY NAME (If not institution, give street and number) Washington Co. Hospital RESIDENCE OF DECEDENT	Bb. CITY, TOWN OR LOCATION OF DEATH Hagerstown Bc. COUNTY OF DEATH Washington										
if. Pages 1,	DIRECTOR	10e. STATE 10b. COUNTY 10c. CI	TY, TOWN OR LOCATION Shepherdstown 10d. INSIDE CI LIMITS? 1 X YES 2										
physician. burial-transit permit.	FUNERAL	Cardinal Lane, Apt. # 1	101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY USA	?									
ding physici the burial-t	BY FU	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yee, specify Cuben, Maxican, Puerto Rican, atc.) 14. RACE — American in Black, White, etc. Specify: White										
tal or attend for use as	LETED	(Specify only highest grade completed) (Give kind of life. Do NOT life. Do NOT	· ·										
by the hospit be detached at once.	COMPL	12 3 Nu:	rse Nursing Home 16. MOTHER'S NAME (First, Middle, Meiden Surname)										
	ш	James Samuel Sites	Martha Riggleman										
5 should notified	0 8		G ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code)	$\overline{}$									
ay be re page 5			B Amy Avenue, Winchester, VA 22603 OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State	3									
director, p		Burial 2 Cremetion 3 Removal from State cemetery cremetory or		VA									
death. Pag funeral dir xaminer		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
ter death. P. the funeral oval.		> Jerry B. Deff	P. O. Box 100, Capon Bridge, WV26	5711									
with pletely fille cremation.		23. PART t. Enter the diseases, or complications that caused the death. Do ehock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS & CONSEQUENCE	Interval	Between nd Death									
th certificate be exect ending physician and I Hygiene prior to bur or other traumati	CERTIFICATION	Sequentially list conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Due to (or as a consequence of): Due to (or as a consequence of): d. d.											
in the	EDICAL	PART II. Other significent conditions contributing to deeth but not resulting	PERFORMED? t YES 2 MO DF OEATH?	PR TO F CAUSE									
been pt. of h	Σ	DID_TOBACCO_USE_CONTRIBUTE_TO_CAUSE_C	F DEATH YES NO F] NO									
SICIAN: The law requires that it certificate has been signed by the State Dept. of Health and I, or item 23 shows any it	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 PES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA	28. PLACE OF DEATH (Check only one) OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) STO Fe High Charge										
NG PHYSIC fter this ce eath with the	ВУ РН	Natural 5 Pending 1/34/84 00	HURY WORK? 1 YES 2 LIMO 174 fo 17ccident										
R ATTENDI RECTOR: A urs after de im 28 is			street, fectory, office 281. LOCATION (Street and Number or Flygal Applie Numbers of Burgal Applied Num	14									
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that TO THE FUNERAL DIRECTOR: after this certificate has been signed by be filed within 72 hours after death with the State Dept. of Health and IMPORTANT: If item 28 is marked, or item 23 shows any	COMPLETE		red at the time, data end place, end due to the cause(e) end manner ee atated.	atated.									
TO THE H TO THE FI De filed w	TO BE (29b. SIGNATURE AND TITLE OF CERTIFIER CONCORD OF CERTIFIER OF CERTIFIER OF CERTIFIER	29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, You DO 1062 11/25/94	(r)									
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (FOR THE COMPLETED CAUSE OF DEATH (ITEM	1. Wo Ching for St 1 toser-stown, 1	C									
		NOV 2 9 1994 Davelear Revolution		7.4									



examiner must be notified at once.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
i examiner must be notified at once.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medica
lai,	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the
er death. Page 6 may be retained by the hospital or attending physician.	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physician.

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	FOR STATE REGISTRAR	STATE OF			RTMENT OF I			ITAL HYGIEN	_		
	1. OECEDENT'S NAME (First, Mile	iddle, Last)					2. (DATE OF DEATH			3. TIME OF DEATH
	RICHARD	EARL		I	LABONTE	SR.		NOV. 25, 1994			3:45 A M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs	GE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.				7 DATE OF BIRTH & BIS			IDI ACE (State or Forming
	216-24-3300	6-24-3300 1 M = 0 F 66 YRS. MONTHS DAYS HOURS MIN. DEC (MONTH) Day, Year) 1927							Count	MASS.	
	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH									DEATH	
DIRECTOR	Memorial Ho		Cumbe	rland			Allegany				
	W.VA.	HAMPSHIRE		- 1	y, town or loca EENSPRIN				10d. INSIC LIMIT 1 YES		
FUNERAL	BOX# 103			10f. ZIP CODE 26722					10g. CITIZEN OF WHAT COUNTS		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Mai 3 Widowed 4 Divorced	IF YES GIVE	INT EVER IN U.S. 1 YES 2 WAR OR DATES	S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Maxican, Puarto Rican, etc.)						14. RACE — American Indian, Black, White, atc. Specify:	
요	15. DECEDE (Specify only hig	ENT'S EDUCATION ghest grade completed)	18a.	DECEDENT'S	USUAL OCCUPATI	DN ost of working		16b. KIND OF BUS	SINESS/IND	DUSTRY	WHITE
COMPLET	Elementary/Secondary (0-12)) College (1-4 or !		WCK D	work done during mose retired.) RIVER	or working		TRUCK D	RIVE	R	
SO	17. FATHER'S NAME (First, Middle	,						irst, Middle, Maiden	Sumame)		
BE		UNKNOWN				MARIE					
0	19a. INFORMANT'S NAME (Type/	•						Number, City or Tow		Code)	
_	KAY F. LaBont				103 GREE				6722		
	20s. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 4 Donatton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campatory or other place) Cumber Clare of Campatory or other place) Cumber Clare of Campatory or other place) Cumber Clare of Campatory or other place)										
	21. SIGNATURE OF FUNERAL SI	ERVICE LICENSEE	t	-	MERRIT		S FUI	NERAL HO		D MA	RYI AND
	23. PART i. Enter the diser shock, or heer iMMEDIATE CAUSE (Final disease or condition resulting in deeth)	e	at caused the cuse on each I	ine.	Cenci.	de of dying,	such ee	cerdiac or respi	retory srr	reat,	Approximate interval Between Onsat and Death
CERTIFICATION	Sequentially liet conditions if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO	O (OR AS A CON	meloseouence o	5 F):						
PHYSICIAN: MEDICAL C	in the flat PERFORMED? 1 yes 2 M/NO							WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
ä	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN X										
SICIA	25. WAS CASE REFERRED TO ME EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER:	on on allerations of					
¥∥	27. MANNER OF DEATH	28a. DATE O		28th TIM	4 Hursing Hon	URY AT	_	Other (Specify) DESCRIBE HOW II	LIUNY DOC	cinen	
ВУ Р	1 X Natural 5 Pen 2 Accident Inve	(Month	Day: Miner)		IURY WO	FES 3 N		DESCRIBE NOW I	and the contract	COMED	
<u>ا</u> ا	2 Solicide 3 Suicide 4 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Round City or Rown, State)								Fourte Mumber;		
COMPLET		ING PHYSICIAN: To the best of) and manner as stated.
H	296. SIGNATURE AND TITLE OF	CERTIFIER	in K		/	20c. LICENSE					(Morrim, Day, Warr)
2	Dr. S. Gupt					1,5000 1000) 2	1502
	31. DATE FILED (Month, Day, Year,) 32. REGISTE	ANS SIGNATUR	Roal R	TCG. DI	uy.,	Cunik	, cr rand	1 EIL	. 2	
ı	NOV 2	0 1994 Jam	C. STONINGER								

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

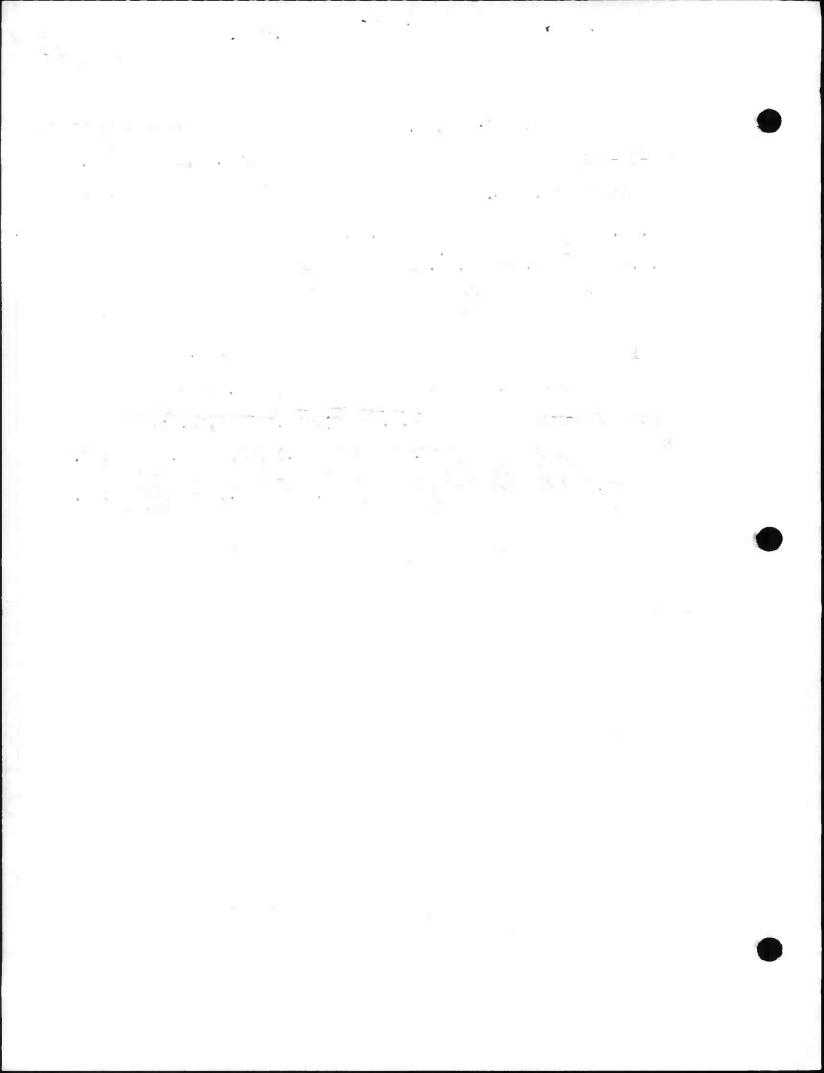
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked. or Item 23 shows any Inlury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

-	_	TIEGIOTIVIT				OLITI	ILICAL	LOF	DEA	111		HEG. NO.				
	ŀ	1. DECEDENT'S NAME (First	, Middle, Last)									TE OF DEATH			3. TIME OF DEA	ТН
		Glenn E. Lininger, Sr. DEC. 07 19									7 D	DOU LOOD A M				
		4. SOCIAL SECURITY NUME			lest hirthrian) IE INDER + YEAR IE IMPER 24 MPS 7 1				7.04	7. DATE OF BIRTH 8. BIRTHPLACE (State or F						
		722-16-04	68 YR	MONTHS		HOURS	MIN.	_ (Mc	onth, Day, Year)	1926 Penna.						
) In		Jan. 30, 1											
	_	9e. FACILITY NAME (If not in		9b. CITY, TOWN OR LOCATION OF DEATH						JNTY OF D		7.				
	5 I	Washingt	on Co	. Hosp.			Ha	ager	stor	wn			Wa	shir	ngton	
	ן ק						7									
	DIRECTOR	10e. STATE	10b. COUNT			10c.	10c. CITY, TOWN OR LOCATION					10d. INSIDE CITY LIMITS?				
	ō	MM.Pa.	Fra	nklin]	Pt.Lo	udo	n				1 X YES 2 NO			
	4	10e. STREET AND NUMBER	127	44 Mair	St.							IZEN OF	WHAT COUNTRY?			
		P.O.Box	236 H	t. Loude	n Pe	17224 17224					USA				- 1	
	FUNERAL	11. MARITAL STATUS	- JU I	12. WAS DECEDEN						-						
	ᅞᅢ	1 Never Married 2	Merried	FORCES? 1	X YES	2 NO	13	If yee, ap	ecify Cub	or, Mexicen	n, Puer	GIN? (Specify Yee to Ricen, etc.)	or No	14. RAC Blac	E American Indi k, Whita, etc.	len,
	וּ מּ	3 Widowed 4 Divo	_	IF YES, GIVE V		ES		1 TYES	2 📉 NO	Specify.	y:			Spec		
	ED														/hite	
	ш	(Specify onl	EDENT'S EDU y highest grade	completed)		16a. DECEDEN (Give kind	T'S USUAL (of work done T use retired.,	during mo	DN ost of worki	ng	1.1	6b. KIND OF BUS	INESS/IN	OUSTRY		
	۳ ا	Elementary/Secondary (0)-12)	College (1-4 or 5	+)							7T 4 75	0			
4	탉	12				ATTITY	nabe) (I	uspe	30 00	ı,	Nat.D	erer	ase		
	COMPLET	17. FATHER'S NAME (First, M	liddle, Last)				-		16. MOT	HER'S NAM	ME (Firs	t, Middle, Maiden	Surneme)			
			Oliv	er H.Li	ning	er			- /	ab [A	H	Linin	0'07			
	BE	19e. INFORMANT'S NAME (7					ING ADORES	e /Stenet /				imber, City or Town		- C- d-1		-
	2	Betty Li		20												- 1
	- 1			<u>T</u> .						r • TO		on.Pa.				
	-	20a. METHOD OF DISPOSIT 1 Department 2 ☐ Crematic		ioval from State	20b. P	PLACE AND DA	TE OF DISPO	SITION (No	me of		0	ATE 20c. LOC	CATION -	- City or To	own, Stata	
	ı	4 Donetton 5 Other	(Specify)		-\$	tenge	r Hi	11	Cem.	12/	10,	/94 Ft	· Lou	idon	.Pa.	1
	- 1	21. SIGNATURE OF FUNERA	LIMMEELI	CENSEE /		565	22	NAME A	ND AODRE	SS OF FAC	CILITY	Fune				
		•	11	A I		10	1	ini	nger	J-F.L	103	F'une	ral	Hom	e	- 1
-	4		11/1			yer	- 4	/ N	. Par	k A	Ve.	Merce	erst	purg	,Pa.	
	- 1	23. PART I. Enter the d	iseeses, or	complications the	t ceused t	the death. D	o not ente	r the mo	de of dy	ing, auch	h es c	ardiec or respin	ratory a	-20	Approxim	
	ł	shock, or heert failure. List only one ceuse on each line.														
	ł	IMMEDIATE CAUSE (Final disease or condition										- 1				
	1	resulting in deeth) a. Small (ell Lung Cancer 20 month) DUE TO (OR AS A CONSEQUENCE OF):										nh				
	- 1	DUE TO (OR AS A CONSEQUENCE OF):										- 1				
	<u> </u>	Sequentielly list conditions,														
		If any, leading to immediate														
	CERTIFICATION	cause. Enter UNDERLY! CAUSE (Disease or Inju		с												
	≐	thet initiated events		OUE TO	(OR AS A C	CONSEQUENCE	OF):									
	Ē	resulting in deeth) LAS	T (d.												1
		DATE II Obbar alreadd a see allean a see a														
	EDICAL	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PINDINGS PERFORMED? ANALABLE PRIOR TO														
	ĕ	1 D MEC a Defi									COMPLETION OF					
												1			OF DEATH?	
	≥	DID TOBACCO U	SE CONT	DIDLITE TO CA	LICE OF	DEATH	VEC [NO E	1 11516	EDTAIN					1 YES 2	NO
	Z			KIBUTE TO CA					1 ONG	EKIAIN						
3	3	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:	20	8. PLACE OF D	OTHE									
3	2	1 TYES 2 THO		1 Inpetient 2	☐ ER/Outpet	lant 3 🗆 DO			e 5 🗆 R	naldence (8 🗆 01	her (Specify)				100
	PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF (Month, D		26b.	TIME OF		URY AT		28d. D	ESCRIBE HOW IN	JURY OC	CURED		
			Pending Investigation	(Month), D	ray, rear)		M		PRK? YES 2 [NO						
	2	2 Suidide		28a, PLACE O	F INJURY -	- At home, fer	n street for				284 14	OCATION (Street a	nd Mumba	e oe Rumi	Bouts Number	
			Could not be determined	building,	etc. (Specify	()	,	itory, orne			C	ity or Town, Stete)	na rvamoe	or nurer	noute Number,	
	COMPLEIED															
į	ᆲ	29a. CERTIFIER 1 CERT	IFYING PHYS	ICIAN: To the best of	my knowled	dge, daeth occ	urred at the	Ilma, data	and place	, end due t	to the	ceuse(a) end man	ner en ste	rted.		
	5			R: On the beels of e											s) end menner as s	stated.
		29b. SIGNATURE AND TITLE														
1	H	On /	, A			l a	0	i	29c. LIC	ENSE NUM		1	29d. DAT		(Month, Day, Year)	
	5	- Michael	1 1/	Milan		M	. 0.		0	416	67)		12.	7.94	
Τ,	-	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAU	SE OF DEAT	H (ITEM 27) (7	rpe, Print)									
		Michael	J.	Mc Corn	nack	m.P.	17	99	How	e11	R	d. 14	801	csho	wa mo	7170
	- 11		-													
	-	31. DATE FILED (Month, Day,	Year)	22. REGISTRA	AR'S SIGNAT	TUBE									7 7 7 7	
		DEC 1 4 19	994	32. RAGISTRA	LOC DA	ball										



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

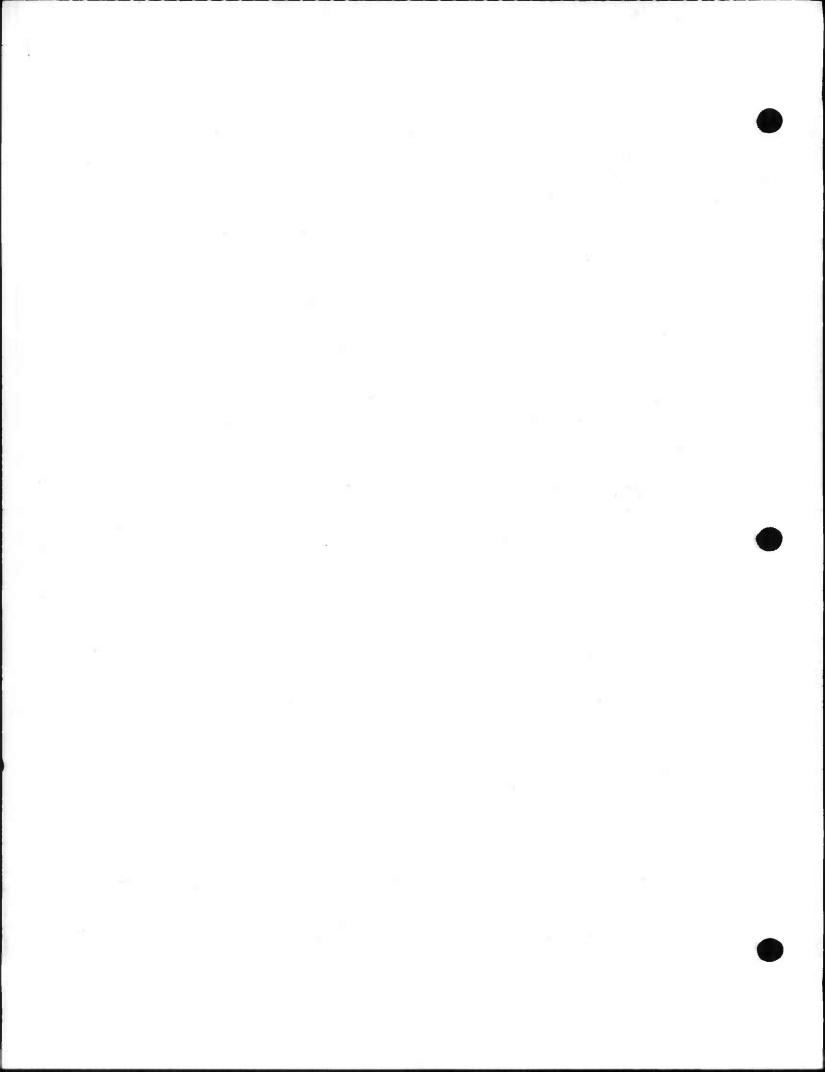
TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death cartificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygher prior tremaint, or removal.

IMPORTABLY: If then 28 is marked or them 23 shows any latent or or prior the marked at marked.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO).					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH				
	Samuel F	dward	Lof1	an d		Nov. 1		5:42 pm				
			GE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign				
	215-26-4646	DEScM 2 □ F	7 1 YAS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)		Country) elaware				
	213 20 4040	213 20 4040 I 12/20/22 D										
1 00	Managian Wasain a same											
DIRECTOR	Memorial Hospita	al at Ea	ston	Eas	ton		Ta	lbot				
	100. STATE 10b. COUNTY		10c. CIT	Y TOWN OR LOCAT	TION			104 INSIDE CITY				
1 %	Maryland Carolino Federal-Lumits											
	10e. STREET AND NUMBER	TOTTHE				rapurg		1 YES 2 NO				
A A				101	I. ZIP CODE		- 7. (- 7. 7 · · · · · · · · · · · · · · ·	OF WHAT COUNTRY?				
빌	4960 Preston Road 21632 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Year of No) 14. BACE — American Indian											
FUNERAL		2. WAS DECEDENT EVE FORCES? 1 \(\subseteq \text{Y}	ER IN U.S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yen, Puerto Ricen, stc.)	e or No— 14.	RACE — American Indian, Black, White, etc.				
B	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR O			2XXNO Specify			Specify: White				
	THE CONTROL OF THE CO											
	15. DECEDENT'S EDUCAT (Specify only highest grade cor	mpleted)	(Give kind of	WORK done during mo	ON est of working	16b. KIND OF BU	SINESS/INDUST	rry				
Щ	Elementery/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	ŕ		Grai	narv					
ĕ D	12		South	ern St	ates		1141					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Malder	Surname)					
BE	Sa	amuel Lo	fland		Mann	ie Rose						
0	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tov						
F	Betty E. Lofla	and	4960	Presto	on Rd.,	Federal	sburg	, MD 21632				
	200. METHOD OF DISPOSITION		20b. PLACE AND DATE	OF DISPOSITION (No			OCATION - City					
	1√Buriel 2 ☐ Cremetion 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	il from State	cemetery, crematory or o	ther place)		1 05+b H	urlool	k, Maryland				
	21. SIGNATURE OF FUNERAL SERVICE LICEN		unry-wa	22. NAME AI	ND ADDRESS OF FA	CILITY	dr rocr	x, Maryland				
	> My Soul 7.	6.6		Fram	otom-Ha	Wkins-Es	kow Fi	uneral Home				
	110001004	0-10070		PO Bo	0x 43.	Federals	burg.	MD 21632				
	23. PART I. Enter the disesses, or con shock, or heart fallure. Lie	mplications that cau	sed the deeth. Do	not enter the mo	de of dying, suci	n es cerdiac or resp	Iratory arrest.	, Approximate				
	IMMEDIATE CAUSE (Final	4		~				Onset and Death				
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. SCALGMIC HEART DISCRESS 1400000000000000000000000000000000000											
	DUE TO (OR AS A CONSEQUENCE OF):											
2												
CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
¥	cause. Enter UNDERLYING											
Ē	CAUSE (Disease or Injury that initiated events	DUE TO (OR A	AS A CONSEQUENCE O	F):								
1	resulting in death) LAST											
5 8	d											
DICAL	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY FINDINGS AMILABLE PRIOR TO											
	LIMEN	ARLY E	4BOLI			1 _ YES		COMPLETION OF CAUSE				
: Н	26660	T COO	2020127	NR45	RY	~		DF DEATH?				
Σ	DID TOBACCO USE CONTRIB				UNCERTAIN			1 123 2 110				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	7012 10 67602	26. PLACE OF DEA		3 OITCERIAII	, , ,						
2		OSPITAL:		OTHER:		- 35 2.5						
<u> </u>	27. MANNEB OF DEATH	28e. DATE OF INJU			Residence	28d. DESCRIBE HOW	IN ILIBY OCCUP	ED.				
	1 Natural 5 Pending	(Month, Day, Ye	nr) IN.	URY WO	PRK?	200. DESCRIBE HOW	INJUNY OCCUR	EU				
M M	2 Accident Investigation	20 BLACE OF IN	IIIW A. b	M 1								
	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (URY — At home, ferm, : Specify)	street, factory, offic	•	28f. LOCATION (Street City or Town, State		Route Number,				
COMPLET	290. CERTIFIER (Check only	N: To the best of my k	nowledge, death occurr	ed at the time, date	end place, end due	to the ceuse(e) end me	nner ee stated.					
M	1							suse(e) end manner ee atated.				
	29b. SKINATURE AND TITLE OF CENTIFIER	-			29c. LIGENSE NUN							
R	Cost L	tree	da ~		1-	- 0 .	290. DATE SIG	GNED (Month, Day, Year)				
2	30. NAME AND ADDRESS OF PERSON WHO C	OMOLEVED ONLINE	7	Deire	1/2	3862	11.	14.74				
Ĭ	WHO C	WIFLE IEU CAUSE OF	UCAIR (HEM 27) (Type	r-mn()	-			1				
		T										
	31. DATE FILED WOM 10 94	32. REGISTRAPIS S	idson-Randal	p								
		0	- Into	_								



1994

9c. COUNTY OF DEATN

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indien, Black, White, etc.

white

21001

Approximate

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

1 TYES 2 NO

OF DEATH?

29d. DATE SIGNED

Onset and Death

1 TES 2 NO

8. BIRTNPLACE (State or Foreign Country)

Maryland

Harford

10g. CITIZEN OF WHAT COUNTRY?

Specify:

USA

2:15 AM M

REG. NO

2. DATE OF DEATH

November

BALTIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

MAE

5. SEX

(mmn)

LENARD

DIVISION OF VITAL RECORDS, P.O. BOX 68760

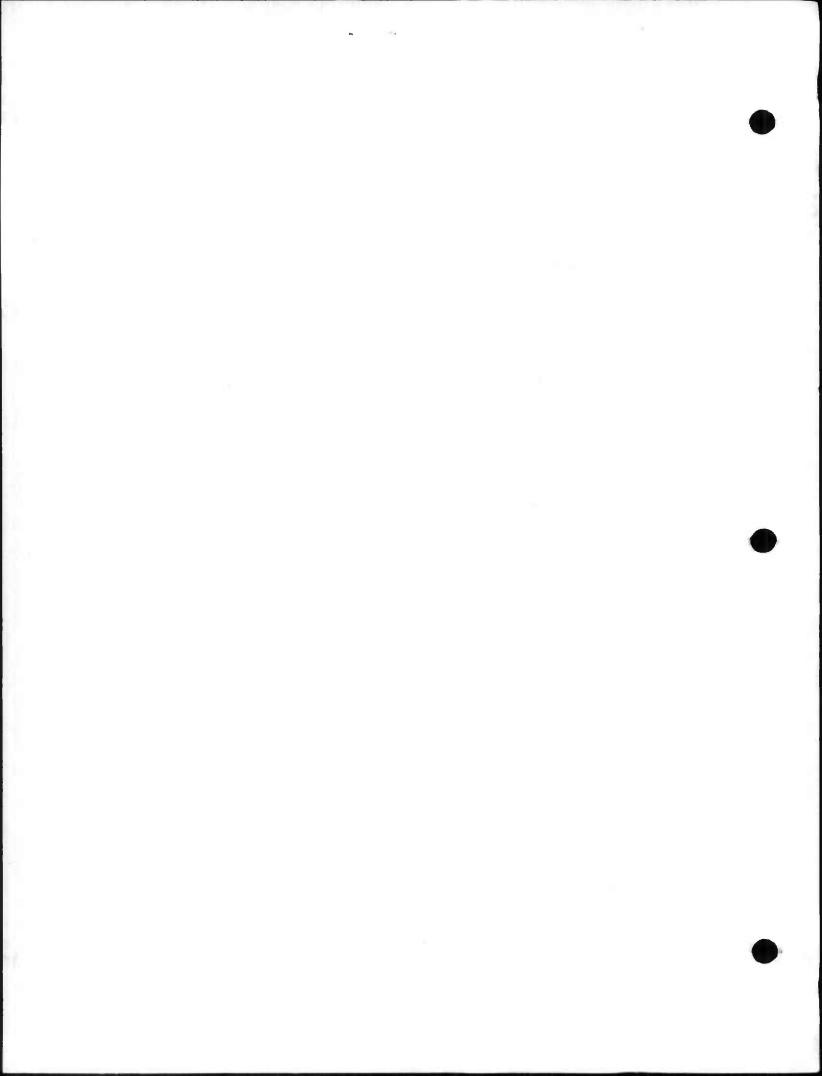
4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. lest birthday, IF UNDER 24 HRS. DAYS 366-24-4129 1 M 2 TF 105 Aug. 17, 1889 funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN DIRECTOR Bel Air Convalescent Center, Inc. Bel Air 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Harford Aberdeen FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 2738 Carsins Run Road 21001 retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify 1 Never Married 2 Merried ΒY 3 🔀 Widowed 4 🗌 Divorced 6 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high COMPLET Elementary/Secondery (0-12) College (1-4 or 5+) Homemaker 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Melden Surneme) George Wesley Long Emly Jane Cooper 智 BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, Stale, Zip Code) 2 Betty J. Lewis 2738 Carsins Run Road, Aberdeen, Maryland rours after death. Page 6 may be Pe 20s. METHOD OF DERIOSITION 20c. LOCATION - City or Town, State DATE must M Buriet 2 vy, cremetory or other place) M. Cemetery 12/1/94 Abingdon, Maryland C Other (Specify) 22. NAME AND ADDRESS OF FACILITY
HOWARD K. McComas III Funeral Home, P.A. examiner 1317 Cokesbury Road, Abingdon, Md. removal. medical 23. BART J. Enter the diseases, or that caused the deeth. Do not enter the mode of dying, such as cardlec or respiratory arrest, shock, or heart fallere. List only one cause on each line. filled in 1 cremation, or IMMEDIATE CAUSE (Final the Wrosepses diseese or condition _____ an and completely fi to burial, cremation event, DUE TO (OR AS A CONSEQUENCE OF): death certificate be executed traumatic CERTIFICATION Sequentially list conditiona, Aung physician a DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): the attending p that initieted events resulting in deeth) LAST 6 Injury, PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? requires that the MEDICAL Health and any 1 TES 2 NO shows been t. of l has b. Dept. PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN: The law in FUNERAL DIRECTOR: After this certificate has be within 72 hours after death with the State Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) ltem. HOSPITAL: OTHER 1 YES 2 NO 1 Inpatient 2 I ER/Outpatient 3 I DOA me 5 🗆 Residence 8 🗀 Other (Specify) 27. MANNER OF DEATH 28s. OATE OF INJURY 28h TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, INJURY 1 Natural 5 Pending м 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28 is 9 4 Nomicide COMPLET tem 29a, CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner as stated TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 29c. LICENSE NUMBER BE on w 2 COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) N. MAIN NAKOWSKi 32. REGISTRAR'S SIGNATURE 31. OATE FILED (Month, Day, Year) NOV 3 0 1994

and walker hartall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

DHMH-16 Rev 1/89



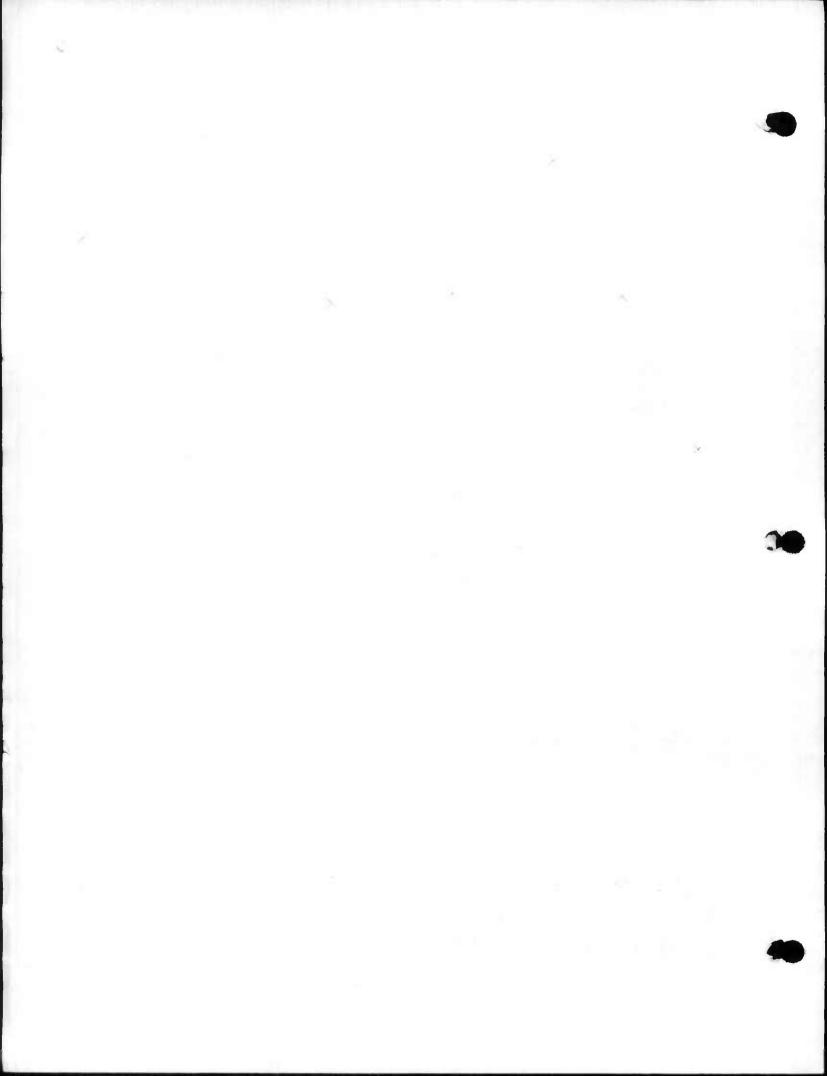
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DIVISION OF VITAL RECORDS, P.O. BOX 13146,	3	du	5	Ne.
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_	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within wours after	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely need in by	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remo	IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medica
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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fter th	ours after death with the State Dept. of Health and Mental Hy	em 28 is marked, or item 23 show
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TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR	STATE OF MARYL		ENT OF HEAD		IENTAL HYGIENE		
1. DECEDENT'S NAME (First, Middle	, Last)				2. DATE OF DEATH		3. TIME OF DEATH
ROSWELL ARTH	UR LINDOW				NOVEMBER 3	0 1994	
4. SOCIAL SECURITY NUMBER	6. SEX 6. AGE	(In yrs. lest birthday) IF I		NDER 24 HRS.	July 1,190	Cou	THPLACE (State or Foreign ntry) SCONSIN
9e. FACILITY NAME (If not institution			CITY, TOWN OR LO	CATION OF DEA		9c. COUNTY OF	
Williamsport Nu	-	W	/illiamsp	ort		Washin	gton
RESIDENCE OF DECEDER	COUNTY	the CITY TO	WN OR LOCATION				10d. INSIDE CITY
Maryland Wa	shington		iamsport				1 YES 2 NO
10e. STREET AND NUMBER	Dodava		10f. ZIP (795		USA	WHAT COUNTRY?
16736 Aqueduct	12. WAS DECEDENT EVER	NII C ADMED			C ORIGIN? (Specify Yes		05 4 4 4 4
1 Never Merried 2 Merries	CORRECT A VICE	2 X NO	If yes, specify (uban, Mexicen	, Puerto Rican, etc.)	Bi	CE — American Indien, ack, White, etc.
3 Widowed 4 Divorced	ir res, ove ton on e	INI ES	1 1 125 2 7	NO Specify:		Sp	White
15. DECEDENT (Specify only highes		16e. DECEDENT'S USU.	AL OCCUPATION done during most of w	nrkina	16b. KIND OF BUS	INESS/INDUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	Operator	ired.)	onung	Power/F	lectric	Utility
17. FATHER'S NAME (First, Middle, L	91)	operacor	10.1	ACTHED'S NAM	NE (First, Middle, Maiden S		0011103
Theodore	Lindow			melia	NE (FRSI, MIOURE, MRIOERI S	Youn	q
19e. INFORMANT'S NAME (Type/Print		19b. MAILING ADD			oute Number, City or Town		
Ione Isabel Lir	ndow				liamsport,		d 21795
20e METHOD OF DISPOSITION 1 Suriel 2 Cremetion 3 [4 Donation 6 Differ (Specific	Removal from State	b. PLACE OF DISPOSITIO		crematory or		erstown	Town, State, , Maryland
21. SIGNATURE OF FUNERAL SERV		dai Lawii i	22. NAME AND AD		CILITY	CI 3 COMII	
· (eac	11/11		OSBORNE				21795
		e our			heague St.		
	a, or complications that cause illure. List only ona cause on a		intar tha moda oi	aying, auch	as cardiac or respii	atory srrest,	Approximets interval Between
iMMEDIATE CAUSE (Final disease or condition	AGDIDAMI						Onset and Dasth
resulting in death)	0	N PNEUMONI A CONSEQUENCE OF):	.A				2 WEEKS
		REBRAL INFA	D C Tr				6 HEEKG
Sequantially list conditions, if any, leading to immediate		A CONSEQUENCE OF):	ikoi				6 WEEKS
cause. Enter UNDERLYING	,						
CAUSE (Disease or injury that initiated events	OUE TO (OR AS	A CONSEQUENCE OF):					
resulting in death) LAST	d						
PART II. Other significant con	nditions contributing to death	but not resulting in th	na undariying csu	se givan in I	Part i. 24s. WAS AN	AUTOPSY 2	4b. WERE AUTOPSY FINDINGS
ALZHEIMERS D					PERFOR	100	AVAILABLE PRIOR TO COMPLETION DF CAUSE
						M wo	OF DEATH? 1 YES 2 NO
					_		
25. WAS CASE REFERRED TO MED			26. PLACE	OF OEATH (Che	ck only one)		
EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Out	patient 3 DOA 4X	HER: Nursing Home 5	Residence (6 Other (Specify)		
27. MANNER OF DEATH	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	26c. INJURY / WORK?	T T	28d. OESCRIBE HOW IF	JURY OCCUREO	
1 X Netural 5 Pendin 2 Accident Investig	9		M 1 TES	2 🗌 NO			
3 Suicide 6 Could 4 Homicide determ	not be building, atc. (Sp.	Y — At home, farm, streeticfly)	t, factory, office		28f. LOCATION (Street e City or Town, State)	nd Number or Run	al Route Number,
	PHYSICIAN: To the best of my know KAMINER: On the best of examination						e(a) and manner ee stated.
29b. SIGNATURE AND TITLE OF CE				LICENSE NUM			ED (Month, Day, Year)
< Tolque	MD			33700			BER 1, 1994
30. NAME AND ADDRESS OF PERS	ON WHO COMPLETED CAUSE OF D	EATH (ITEM 27) (Type, Prin					, -,, -,,,
TED E. HOWE,		RTIZAN STRE	ET, WILL	IAMSPO	RT, MD 217	95	
DEC 0 2 19	PAL REGISTRAR'S SIG	- fandall					

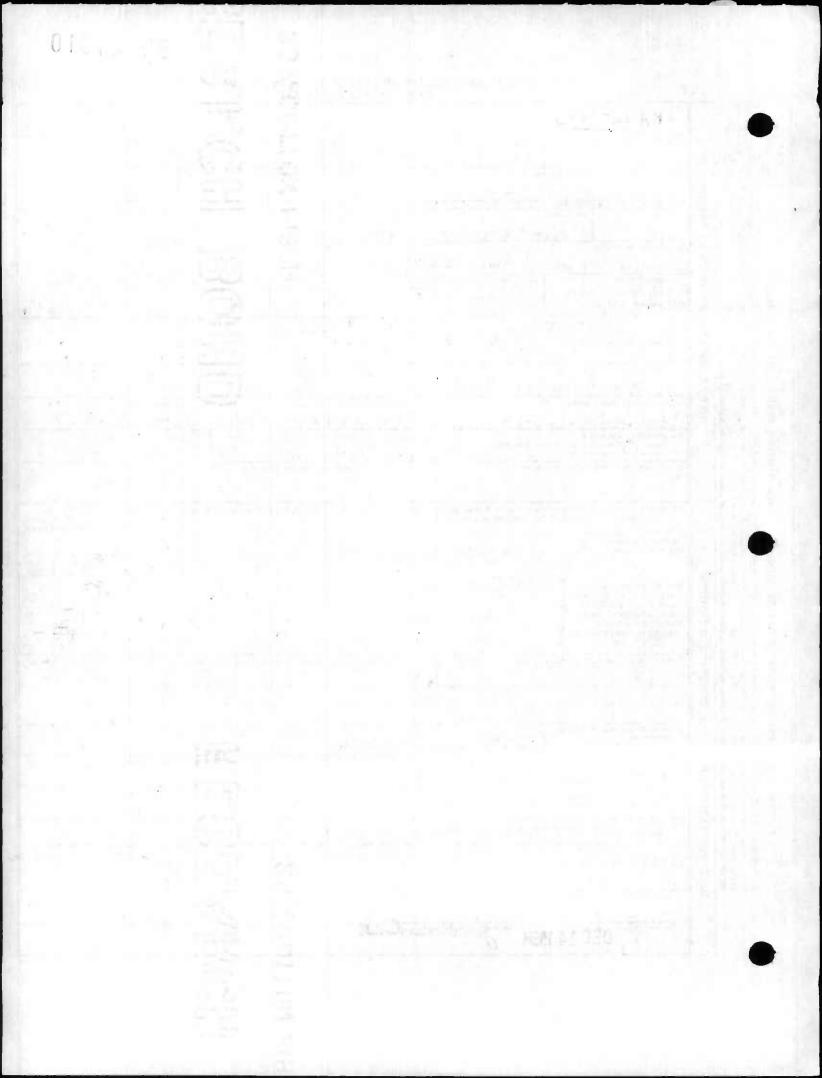


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BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physician.	y filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL, DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the		be notified at once.
hours after death. Page 6 mil	ely filled in by the funeral director.	nation, or removal.	, the medical examiner must
the death certificate be executed with	the attending physician and complete	! Mental Hygiene prior to burial, crem	njury, or other traumatic event
PHYSICIAN: The law requires that t	this certificate has been signed by	with the State Dept. of Health and	ted, or item 23 shows any i
TO THE HOSPITAL OR ATTENDING F	TO THE FUNERAL DIRECTOR: After I	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
t. DECEDENT'S NAME (Elrat, Middle, Las	" MEEHAN		3. N. C.	2. DATE	OF OEATH DAY	9re	3. TIME OF GEATH			
4. SOCIAL SECURITY NUMBER	1 M 2 D F	YRS. lest birthday) YRS.	NDER 1 YEAR IF UNDER 24 HRS THS DAYS HOURS MIN.		OF BIRTH		HRTHPLACE (State or Foreign ountry)			
90. FACILITY NAME (If not institution, give street end number) 96. CITY, TOWN OR LOCATION OF DEATH BALTUMORE CITY RESIDENCE OF DECEDENT 96. COUNTY OF DEATH BALTUMORE CITY										
10e. STATE 10b. COUL	ALTIMORE		T MORE				10d. INSIDE CITY LIMITS? t YES 2 NO			
2601 POPLAN	2601 POPLAK DRIVE 350 101. ZIP CODE 21207 US									
ti. MARITAL STATUS t Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DATE	PANIC ORIGII ilcen, Puerto icily:	N? (Specify Yee or Ricen, etc.)		RACE — American Indian, Black, White, etc. Specify Cauce Black					
15. DECEOENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY										
17. FATHER'S NAME (First, Middle, Last)	UDEN MORR	(A) (-	18. MOTHER'S	NAME (First,	Middle, Maiden Su	mame)	41)			
190. INFORMANT'S NAME (Type/Print) BALBARA M			RESS (Street end Number or Rus		ber, City or Town,		0)			
20e. METHOD OF DISPOSITION t Buriel 2 Cremetion 3 Re 4 Donation 5 Other (Specify)		PLACE AND DATE OF OIS tery, cremetory or other p	- 1	8 001	E 20c. LOCA	Bal	or Town, State			
21. SIGNATURE OF FUNERAL SERVICE	LICENSEE		22. NAME AND ADDRESS OF	FACILITY . S	olic	D Gr 3	- AUE			
23. PART I. Enter the diseases, cahook, or haart failur IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Incutal	isce Ab	onter the mode of dying, a	uch aa car	diac or reapirer	tory arreat,	Approximate Interval Betwee Onset and Daal			
Sequantially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):	or							
PART II. Other significant conditions	iona contributing to death bu	it not resulting in th	e underlying cause given	in Part I.	24a. WAS AN AL PERFORMI 1 VES 2	ED?	24b. WERE AUTOPSY FINDING AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26, PLACE OF DEATH							
1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	1 Linpatient 2 ER/Outpa 28e. OATE OF INJURY (Month, Day, Year)	28b. TIME OF	Nursing Home 5 Reeldend 28c. INJURY AT WORK? M 1 YES 2 NO		er (Specify) SCRIBE HOW INJ	URY OCCURE	60			
2 Accident Investigatio 3 Suicide a Could not independent determined	28e. PLACE OF INJURY - building, etc. (Specia	— At home, farm, atreat		City	CATION (Street and or Town, State)	1 1	ural Route Number,			
anal	YSICIAN: To the best of my knowle				use(a) end manne	or ee stated.	0			
296. SIGNATURE AND TITLE OF CERTIF		mo	29c. LICENSE I				3 94			
30. NAME AND ADDRESS OF PERSON Angela	WHO COMPLETED CAUSE OF DEA		inai Hosp	الما	106	Bal	to			
31. DATE FILED (Month OF CT14	1994 32. REGISTRATE 1975		u s	1						



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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

1 -		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND	MENTAL	HYGIENE
_	REGISTRAR	CERTIFICATE OF DEATH		REG. NO.
1 1	ECEDENT'S NAME (First Middle I not)			C 0.C 4.711

		NEGIO I NAN				CERTIF	ICAIL	. OF	DEATH		REG. NO			
		1. DECEDENT'S NAME (First,	Middle, Last)								TE OF DEATH	NY 1	YEAR 3.	TIME OF DEATH
		HELEN ALDONA MARCIN								Dec	December 2, 1994			№ MY 00:8
	l	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In yrs		IF UNDER	DAYS	IF UNDER 24 HR		TE OF BIRTH onth, Day, Year)	6.	Country)	ACE (State or Foreign
목	1 1	189-26-3501		1 □ M 2√2 F	84	YRS.				Dec	. 3, 19			sylvania
pinous	~	9a. FACILITY NAME (If not in:					9b. CITY,	TOWN C	OR LOCATION OF			9c. COUNT		
2, 3	١٥	Bel Forest Nursing & Rehab. Center				L		Fore	st H	ill	H	larfo	ra	
Jes 1.	DIRECTOR	10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN O	R LOCAT	TION				10	Id. INSIDE CITY
2	片	Maryland Harford					F	orest 1	Hill			1	LIMITS?	
permit. Pages	A	10s. STREET AND NUMBER		<u>-</u>	-		10f, ZIP CODE			10g. CITIZE	10g. CITIZEN OF WHAT COUNTRY?			
50	FUNERAL	109 Forest V	alley	Drive			21050			USA				
physician, bunal-transit	5	11. MARITAL STATUS		12. WAS DECEDEN					PANIC OR	GIN? (Specify Yes	or No-	I. RACE —	American Indian, /hita, atc.	
e bur	ВУ	1 Never Married 2 Married FORCES? 1 YES 2 3 Wildowed 4 Divorced FFORCES? 1 YES 2							to Hican, etc.)		Specify:	TIVER, MIC.		
as the	E B													white
or afte	ETE	(Specify only	highest grade	completed)		(Give kind of life. Do NOT us	work done a				16b. KIND OF BU	SINESS/INOUS	TRY	
pital o		Elementary/Secondary (0-	-12)	College (1-4 or 5	+)		hool	The s	ahor	-	ublic	Educa	tion	
the hospit detached once.	COMPL	17. FATHER'S NAME (First, Mi	(ddle, Last)	JT		50	1001	Tea		_			TOIL	
at be d	Ö	Paul Peter Grablick					16. MOTHER'S NAME (First, Middle, Melden Surname) Anna Kedanis							
5 should	00	19a. INFORMANT'S NAME (7)				19b. MAILING	ADDRESS	(Street a		ral Route N	lumber, City or Tow		ode)	
e reta	임	Stephen G. N	Marcin		-						Bel Ai			nd 21015
nay be page		20a. METHOD OF OISPOSITI	ON _			CEANDDATE	OF DISPOSI	_				CATION - CI		
fours after death. Page 6 may be retained by the hospital or attending physician, d in by the funeral director, page 5 should be detached for use as the bunial-fran or removal. medical examiner must be notified at once.		4 Donation 5 Other		IVEL TROM: State	cemetery All	Saint	ther place) S Cen	nete	ry	12/8	5/94 N∈	wark,	Dele	ware
death. Pag e funeral die I. examiner		21. SIGNATURE OF FUNERAL	service yo	ENSUE ///	1	97			ND ADDRESS OF	FACILITY				
death. P. funeral		> /hou	NI	/ ///		J					III Fu			
rs after of n by the removal.		23. PARI I. Enter the di	sedeća, or c	omplications the	t caused tha	death, Do	not enter	tha mo	de ot dving.	LY RC	ardiac or respi	retory arres	e IVICI.	21009 Approximate
d in by the or remove	1	shock, or he	eart fallura. L	List only one car	uae on aach	line.			, ,				.,	Intarval Between Onset and Death
with pletely fille cremation, vent, the		iMMEDIATE CAUSE (Fin disease or condition	ai -	1. 7	_	,	11							Onest and Death
completely filled ial, cremation, or event, the m		resulting in death)	,	DUE TO	(OR AS A CO	SEQUENCE O	F):		me	0	4			
and com to burial, matic ev	z	C b.												
e be execut sician and c nor to buni traumatic	CERTIFICATION	Sequantially list conditions, if any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF												
physician physician one prior to	2	cause. Entar UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF):												
sing p ygien		that initiated eventa resulting in death) LAS		DUE TO	(OR AS A CON	ISEQUENCE O	F):							
attendatte Hutal H	岗	d												
the d the d d Me		PART II. Other eignitical	nt conditions	s contributing to	death but n	ot reaulting	In the un	dariyin	g cause givan	in Part I	. 24a. WAS AN PERFOR	AUTOPSY		ERE AUTOPSY FINDINGS
that the and any	EDICAL										1 TYES 2	4 4	CO	MILABLE PRIOR TO IMPLETION OF CAUSE F DEATH?
quires n sign r Heal	ME										1		1	YES 2 NO
b bee														
The ta	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:					LACE OF DEATH	(Check onl	y one)			
triffica	YSI	1 TES 2 NO		1 Inpetient 2	ER/Outpatien	t 3 🗆 DOA	OTHER 4 Nurs		ne 5 🗆 Raalden	ca 8 🗆 C	ther (Specify)			
HYSIC nis ce with ti	РНУ	27. MANNER OF DEATH Natural 5		28a. DATE OF (Month, E		28b. TIN	IE OF	28c. INJ WO	URY AT	28d.	DESCRIBE HOW I	NJURY OCCU	RED	
NG Pi fter th	ВУ		Pending investigation				М		YES 2 NO					
TENDI OR: A Iter d	9		Could not be detarmined	28a. PLACE C building,	of INJURY — A atc. (Specify)	t home, farm,	street, facto	ory, offic			OCATION (Street in City or Town, State)		Rural Route	e Number,
R ATT RECTI UIS al	Ш													
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior tiMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traus	COMPL			CIAN: To the best of										
UNER UNER rithin	00	2 MEDI			xamination and	I/or Investigation	on, In my o	pinion, d	leath occured at	the time, o	lete and place, ar	d due to the	:euse(s) an	nd manner as stated.
H H H B B B B B B B B B B B B B B B B B	BE	29b. SIGNATURE AND TITLE	OF CERTIFIER						29c. LICENSE	NUMBER				onth, Day, Year)
₽ ₽ ₽ %	10	Davy S.	Dun						1)35	297		1	2/3/	12/
		30. NAME AND ADDRESS OF					Print)							
		31. DATE FILED (Month, Day,	Mean)	32 AGOUSTON	1 15 el A	IRE RI	V	_						
		DEC 0	5 1994	32 Agapting	twologra	Karlall								
				11										

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR	SINIC OF I	CERT	IFICAT	E OF	DEAT	H.	REC	GIEN G. NO			
	1. DECEDENT'S NAME (First, Middle, Las							2. DATE OF DEATH MONTH DAY YEAR			3. TIME OF DEATH	
	WAYNE E. MAY							DEC -		76	94	1.35P M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest birtho	//	R 1 YEAR	IF UNDER		7. DATE OF BIR (Month, Day,	TH			PLACE (State or Foreign
	217-58-3450	1 XM 2 - F	42 YR	S. MONTHS	DAYS	HOURS	MIN.	OCT. 28	3,	1952		
_	9a. FACILITY NAME (If not institution, give	street and number)	WATEMAIN	9b. CIT	Y, TOWN C	R LOCATIO	N OF DEA	TH		9c. COL	NTY OF D	EATH
P 0	BAY SOUTH OF	WEST RI	VER							AN	NE A	ARUNDEL
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUR	Arlingto	10c.	CITY, TOWN	OR LOCAT	ION		_				10d. INSIDE CITY
E	VIRGINIA ALE	YANDRIA		ALEX	ANDR	A A	rling	iton				LIMITS?
	10e. STREET AND NUMBER	MINIOR III		AULA		ZIP CODE	-	11011		10g. CIT	IZEN OF W	VHAT COUNTRY?
FUNERAL	5615 WILSON BLVD) .				2025				IT (5.A.	
5	11. MARITAL STATUS	12. WAS DECEDEN	TEVER IN U.S. ARMED	13.	WAS DEC	ENDENT OF	F HISPANI	C ORIGIN? (Spe	cify Yes		14. RACE	- American Indian,
BY	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE Y	AR OR DATES			2 XNO		Puerlo Ricen, a	MG.)		Speci	fyr
	15. DECEDENT'S EI	VIETN		TIS HOURT A	2001184710			I and a second			WHI	TE
	(Specify only highest gra	de completed)	life Do MC	i of work done of use retired.	during mo	st of working	9	16b, KIND	OF BU	SINESS/IN	DUSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5	VICE P					CONT	וכווחי	riomr/	NT 00	N COANTY
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	-	SUPE	RIMTE	MANI		ER'S NAM	E (First, Middle,			IN CC	MPANY
BE C	NORMAN FRANCI	S MAY,	SR.			SHT	RLEY	ANI	J	SCHI	ROCK	
TO B	19a. INFORMANT'S NAME (Type/Print)			ING ADDRES	S (Street a			oute Number, City				
۲	SUSAN A. MAY		5615	WILSO	ON BI	.VD.,	ARL	INGTON	, V.	A. 22	2025	
	20a. METHOD OF DISPOSITION 1 XBurlel 2 Cremation 3 Re	moval from State	20b. PLACE AND DA			me of		OATE 2	20c. LO	CATION -	City or To	wn, Stata
	4 Donation 5 Other (Specify)	Villagia de	RESTHAVE	N MEMO	DRIAL				FR	EDER:	CK,	MD
1	21. SIGNATURE OF FUNERAL SERVICE	CICEMBEE	_			O ADDRES		ility EY & S(TAC	T) 7		
	2//			[6:	15 E.	MAT	N ST	. THUE	RMOI	NT.	4D 21	788
	23. PART I. Enter the diseases, of ahock, or heart fellung	r complications the	t ceused the death. I	o not ente	r the mo	de of dylr	ng, such	as cardlec or	reap	iratory sr	reet,	Approximete interval Between
	iMMEDIATE CAUSE (Final disease or condition	0 -										Onset and Death
	resulting in deeth)											
_	DUE TO (OR AS A CONSECUENCE OF):											
Ó	Sequentially list conditions, if any, leading to immediate	b. DUE TO	(OR AS A CONSEQUENC	E OF):						_		
CA	ceuse. Enter UNDERLYING CAUSE (Disease or Injury	C										
	that initiated events	DUE TO	(OR AS A CONSEQUENC	E OF):				1				
CERTIFICATION	resulting in deeth) LAST	d										
	PART II. Other significent conditi	ons contributing to	death but not resulti	ng In the u	nderlying	cause g	iven in P	art I. 24a. V		AUTOPSY	24b.	WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL										RMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
Ä												OF GEATH?
ž	DID TOBACCO USE CON	TRIBUTE TO CA	USE OF DEATH	YES	NO [UNC	ERTAIN					7
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF E	OTHE								
YSI	XX YES 2 □ NO	1 Inpatient 2	☐ ER/Outpetlent 3 ☐ DO	A 4 Nu	raing Hom	o 5 □ Red	eldence X	X Other (Spec	ify)	BAY	ARI	EA
	27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF (Month, L	Pay, Year)	TIME OF		RK?		28d. DESCRIBE		, ,	2	
B	2 Accident Investigation			500 M		ES 2 9	_	- 5/	eci			nec
3 Suicide s Could not be determined 28. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 28. PLACE OF INJURY — At home, term, street, tectory, office City or Town, State) City or Town, State) Suy Suith of West							2.5					
							est Rive					
29a. CERTIFFIER (Check only one) 1 CERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. X MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as as												
	295. SIGNATURE AND TITLE OF GERTIE		/	patron, in my	ориноп, а				ace, an			
8	The second second second	920	-4			29c. LICE						(Month, Day, Year)
						() _ (C.M.	E.			EC.	07/94
임	30. NAME AND ADDRESS OF PERSON V	VHO COMPLETED CAU	SE OF DEATH (ITEM 27) (Type, Print)		-						01/04
۲	30. NAME AND ADDRESS OF PERSON V	VHO COMPLETED CAU			reet			more	м			
ĭ	30. NAME AND ADDRESS OF PERSON W 31. DATE FILEO (Month, Day, Yber)	32. REGISTRA		n St	reet			more,	M			21201

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should		
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S after	by the	the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	id, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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OR ATT	HE FUNERAL DIRECTOR: After this	nours at	tem 2
SPITAL	NERAL	hin 72 h	NT: IF
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUI	be filed within 72 hours after death with the	PORTANT: If Item 28 is marked
2	2	2	Ξ

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)	an Mccini	. 1	ior		2. DATE OF DEATH	DAY YEAR	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 219-12-0026							HPLACE (State or Foreign		
OR	Shady Grove Adv	Shady Grove Adventist Hospital Shockville						DEATH		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Maryland Mc	ontgomery Damascus					10d. INSIDE CITY LIMITS? 1 YES 2 A NO			
FUNERAL	100. STREET AND NUMBER > 251.07 Oak I	rive	<u> </u>	10	20872			what country? d States		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 TYES	2 X NO	If yes, sp		NIC ORIGIN? (Specify Year, Puerto Rican, atc.)	Blac	E — American Indian, ck, Whila, etc.		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		life. Do NOT us	ork done during mo	ON ost of working	10	rming			
	17. FATHER'S NAME (First, Middle, Lest)	AcClain, Sr.				ME (First, Middle, Maider nes Fink				
TO BE	19a. INFORMANT'S NAME (Type/Print) Marjorie G. M				and Number or Rural	Route Number, City or Tov		2		
	Marjorie G. McClain 25107 Oak Drive, Damascus, Md. 20872 20a. METHOD OF DISPOSITION 17 Buria! 2 Cremation 3 Ramoval from Stala 4 Donation 5 Other (Specify) 20b. PLACE AND DATE Of DISPOSITION (Name of cemetery, crematory or other piece) Mount Olivet 12/8/94 Frederick. Maryland									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872									
TION	23. PART i. Enter the diseasea, or complications that caused the death. Dp npt enter the mode of dying, such as cardiac or respiretory arrest, shock, pr heart failure. List pnly one cause on each line. IMMEDIATE CAUSE (Finei disease or condition resulting in death) Due to lor as a consequence of: Sequentially list conditions, if any, leading to immediate BUE TO (OR AS A CONSEQUENCE OF): BUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease Dr Injury that Initiated events resulting in death) LAST Compared to the property of									
AL	PART II. Other significent condition	na contributing to death b	ut not resulting i	n the underlyin	g cause given in		RMED?	b. WERE AUTOPSY FINDINGS AWARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ANO		
PHYSICIAN: MEDIC	DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		CAUSE OF		LACE OF DEATH (Ch					
IYSIC	1 YES 2 NO	HOSPITAL: 1 Inputient 2 ☐ ER/Outp	atlent 3 DOA		ne 5 🗆 Rasidence	6 Other (Specify)				
BY PI	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	M 1 🗆	ORK? YES 2 NO	28d. DESCRIBE HOW				
ETED	3 Suicide 6 Could not be determined	26a. PLACE OF INJURY building, etc. (Spec	— At home, Jerm, s	treet, factory, offic		281. LOCATION (Street City or Town, State		Route Number,		
COMPLETED		ICIAN: To the best of my knowless: On the beats of axamination						(a) and menner as stated.		
띪	29b. SIGNATURE AND TITLE OF CERTIFIE	MBER	29d. DATE SIGNE	D (Month, Day, Year)						
2	30. NAME AND ADDRESS OF PERSON WH Robert L. G	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type,	Print)	fore 12	and Ray	trillo	Md20850		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAP'S SIGN	ATURE	,		. , , , , ,	1511/16	,		

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 DECEDENT'S NAME (First Middle I not 2. DATE OF DEATH 3. TIME OF DEATH YEAR 94 MONTH 12 LILLIAN ESTELLE MAHER 7:40 AM 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 7/5/1911 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 212-20-9610 1 M 2 XF 83 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN c. COUNTY OF DEATH DIRECTOR Frederick Memorial Hospital Pages 1, 2, 3 Frederick Frederick RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Frederick Frederick 1 X YES 2 NO permit. FUNERAL 10a STREET AND NUMBER I.O.O.F. Home 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit North Market Street 21701 U.S.A. the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Markean, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black. White, atc. BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) funeral director, page 5 should be detached for College (1-4 or 5+) 10 years N/A Bookkeeper Construction 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) To LeRoy Draper Sr. Katharine Kelly H notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Winnie M. Ronev 836 Waterford Drive Frederick, Maryland 21701 ours after death. Page 6 may be pe METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State must Buriel 2 Cremation 3 Removal from State New Cathedral Cemetery Donation 5 Other (Specify) 12/6 Baltimore City, Maryland examiner 21. SIGNATULUL OF FU 22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, illed in by the medical 23. PART I. Solar the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiec or respiratory arrest, ehock, or heart fellure. List only one ceuse on each line. Interval Between Onast and Death IMMEDIATE CAUSE (Finel Louters cremation, the a ceselr diseese or condition and completely 1 to burial, cremation les resulting in death) event. DIVISION OF VITAL RECORDS, P.O. BOX 68760, O (OR AS A CONSEQUENCE OF) executed traumatic CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): 2 if any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to certificate be CAUSE (Disease or Injury that initiated eventa other 1 DUE TO (OR AS A CONSEQUENCE OF). resulting in death) LAST 0 PART II. Other aignificant conditions contributing to death but not recuiting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL MAIL ARLE PRIOR TO any COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO 1 - YES 2 - NO has been s Dept. of H PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate h HOSPITAL: 1 YES 2 14 NO OTHE Inpatient 2 ER/Outpatient 3 DOA ne 5 🗆 Residence 6 🗆 Other (Specify) 4 3 8 0 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED this with 1 Netural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death vitem 28 is mart BY 2 Accident OR ATTENDING 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. TO THE HOSPITAL TO THE FUNERAL C be filed within 72 h (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 29h. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day, Year) BE Kelin 10 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)



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BALTIMORE, MARYLAND 21215-0020	precured with another after death. Page 6 may be retained by the bosonical or attending observed
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DIVISION OF VITAL RECORDS, P.O. BOX

TO THE HOSPITAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed with the standard law to the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merical Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL HYGIEI						
	1. DECEDENT'S NAME (First, Middle, Las A L+A			A	q q'E	3. TIME OF DEATH						
	4. SOCIAL SECURITY NUMBER 21.8-10-8499 90. FACILITY NAME (If not institution, give	1 🗆 M 2 🏋 F	(In yrs. lest birthday) IF 90 YRS. MO	7. DATE OF BIRTH (Month, Day, Year) Mar. 15, 19	r) Country)							
TOR		W Nursing Home	R LOCATION OF C	DEATH		roll						
DIRECTOR	Maryland 10b. cour	Howard	10c. CITY, T	OWN OR LOCAT	. Airy			10d. INSIDE CITY LIMITS? 1 YES 2 NO				
FUNERAL	16721 Frederi	Lck Road		10f	21771		10g. CITIZEN OF WHAT COUNTRY? United States					
ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	If yes, spe		NIC ORIGIN? (Specify Wan, Puerto Rican, etc.)		RACE — American Indien, Black, White, etc. Specify: White					
COMPLETED	15. DECEDENT'S E (Specify only highest gra Elementary/Secondary (0-12)		16a. DECEDENT'S USI (Give kind of work life. Do NOT use re Homem.	done during mo- tired.)		Jieconio i i jes	home	RY				
BE COM	17. FATHER'S NAME (First, Middle, Last) William E	. Molesworth	Ma	AME (First, Middle, Melde, rgaret Cod	Surname)							
10	190. INFORMANT'S NAME (Type/Print) Margaret E. St 200. METHOD OF DISPOSITION			Frederi	ck Road	, Mt. Airy		21771				
	23. PART I. Enter the diseases, or compileations that caused the desth. Do not anter the mode of dying, such as cardiac or reapiretory arrest, immediate CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of):											
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST		days									
PHYSICIAN: MEDICAL CI	PART II. Other significant conditions of the significant condition	ions contributing to death b	out not resulting in t	he undarlying	j cause given ii	Pert i. 24e. WAS A PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO				
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)											
ВУ РНУ	27. MANNER OF DEATH 1 Neturel 5 Pending 2 Accident Investigatio	27. MANNER OF DEATH 280. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? M 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED										
	2 Solicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
COMPLETED		YSICIAN: To the best of my know						use(s) and manner as stated.				
TO BE	296. SIGNATURE AND TITLE OF CEPTUFIER 296. LICENSE NUMBER											
	30. NAME AND ADDRESS OF PERSON OF MOUNTAIN KINDS	N 4801088	y 12011 Dr	m 2111	with Co	ty Wi	2104	15				
	DEC 0 2 19	32. RESISTRANCE SIGN	har Rentally									

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BALTIMORE, MARYLAND 21215-0020	executed within Jurs after death. Page 6 may be retained by the hospital or attending physician.	n and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
IMORE, MAR	Page 6 may be retained	Il director, page 5 should
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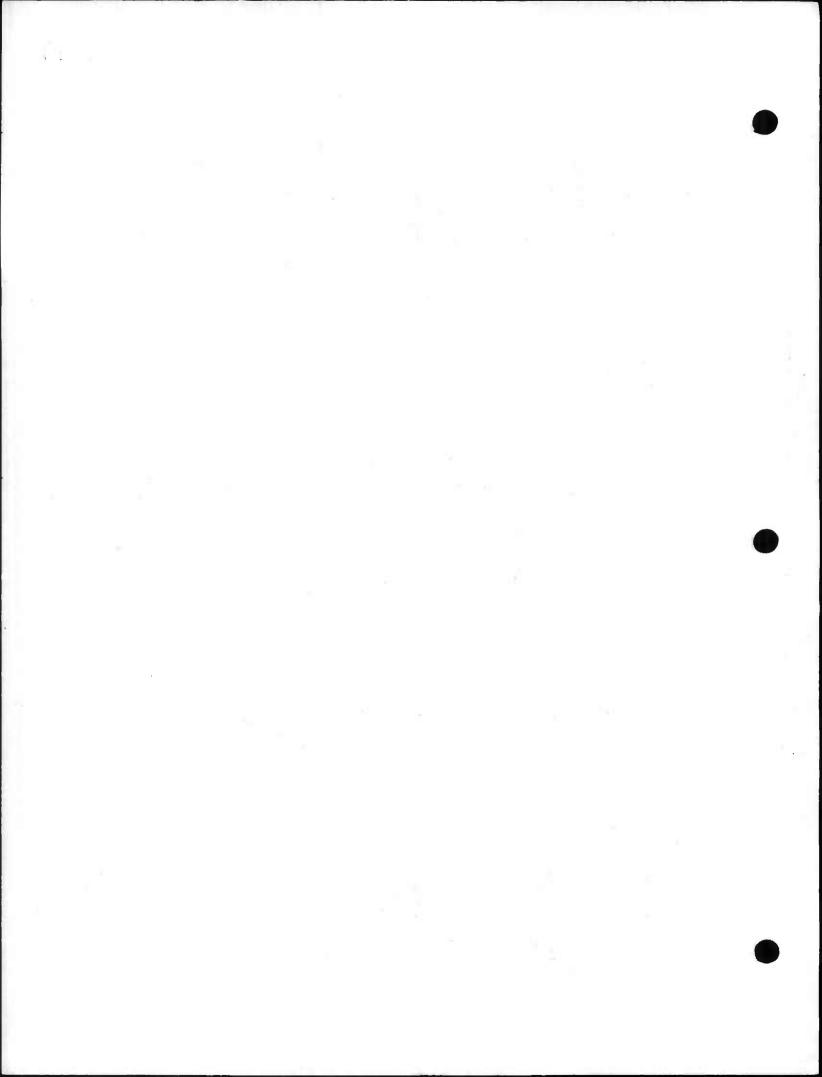
DIVISION OF VITAL RECORDS, P.O. BOX

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	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ours after death. Page 6 may be retained by the hospi	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for funding the formula of removal.	IMPORTANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	TATE OF MARYLA		TMENT OF			HYGIENE REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last) Helen M. Moffett						DEATH	994 '	FAD	IME OF DEATH		
	217 01 6587	7 01 6587 1 □ M 2 X F 86 YRS. MONTHS DAYS HOURS							Mary	E (State or Foreign 7 Land		
TOR	9a. FACILITY NAME (If not institution, give street at 1885 German Chap RESIDENCE OF DECEDENT	e Fred			Cal							
DIRECTOR	10a. STATE 10b. COUNTY	ia. STATE 10b. COUNTY 10c. CITY, TOWN							10d. INSIDE CITY LIMITS? 1 UPS 2 TO NO			
FUNERAL	100. STREET AND NUMBER 1885 German Cha	30						ited States				
BY FUN	11. MARITAL STATUS 12. 1 Never Married 2 Married 3. Widowed 4 Divorced	If yes, s	CENDENT OF HISPA pecify Cuban, Mexic 3 2 NO Spec	an, Puerto Ric		r No — 14	14. RACE — American Indian, Black, White, atc. Specifiwhite					
COMPLETED		N (leted) Hege (1-4 or 8+)	Me. Do NOT us	vork done during m retired.)	ON ost of working	1	IND OF BUSIN		TRY			
MP	unknown 17. FATHER'S NAME (First, Middle, Last)		house	wile			wn ho					
		h			16. MOTHER'S N							
BE	John German Smit	.11	Em manua			se V.		-				
5	Edward R. Smith S	~			Chane					rai aleMD		
- 1	20s. METHOD OF DISPOSITION						_			erickMD		
	19 Burlel 2 Cremetion 3 Remove from State Application of Conter (Specify) Barstow Maryland											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic N											
CERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):											
MEDICAL	PART II. Other algnificant conditions co		DERFORM	ED?	COM OF E	E AUTOPSY FINDINGS LABLE PRIOR TO PLETION OF CAUSE SEATH? YES 2 NO						
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				LACE OF DEATH (C	heck only one)						
SIC		SPITAL: Inpatient 2 - ER/Outpa	itlent 3 🗆 DOA	OTHER:	ne 5 Residence	8 🗆 Other (S	Specify)					
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	H 25a. DATE OF INJURY (Month, Day, Year) 25b. TIME OF INJURY AT WORK?						28d. DESCRIBE HOW INJURY OCCURED				
ED	2 Accident 3 Suicide 6 Could not be building, etc. (Specify) 28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28f. LOCATION (Street and Number or Ru City or Town, State)									Number,		
COMPLET	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On									manner as stated.		
TO BE C	296. SIGMATURE AND TITLE OF CERTIFIER	11/1	1	Ann	29c. LICENSE NU	3123		29d. DATE S	IGNEO (Mon	th, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO CO Jonathan Lowenth				d. Pri	nce F	redei	cick	Mary	land		
	31. DATE FILED (Month, Day, Year) DEC 2 1994	32. REGISTRAR'S SIGNA										



		1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF H		MENTAL HYG					
		1. DECEDENT'S NAME (First, Middle, Las)				2. DATE OF DEAT	H DAY	YEAR 3. 1	TIME OF DEATH		
		Nellie McDan	iel				Dec. 4	. 1994		7 A.	M	
		4. SOCIAL SECURITY NUMBER	200 000	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Yea		8. BIRTHPLAN	CE (State or Foreign		
목		213-03-5257	1 DM 2 DF	84 YRS.			12-18-	-09		land		
3 should	Œ,	9e. FACILITY NAME (If not institution, give			96. CITY, TOWN	OR LOCATION OF D	EATH	9c. COUN	ITY OF DEATH	1		
2,	рівестря	2 7 Mackall Street Elkton Cec										
ges 1,	<u> </u>	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION										
2.	ā	Marvland	Cecil		Firto	N + i			10	LIMITS?		
permit. Pages	¥	10e. STREET AND NUMBER			10	ZIP CODE	**	10g. CITIZ	ZEN OF WHAT	COUNTRY?		
020 physician. burial-transit	FUNER	1 227 Mackall S	Street			2192	1	Ţ	J. S.	Α.		
20 ysicia	훈	11. MARITAL STATUS 1 Never Married 2 Merried	12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED			NIC ORIGIN? (Specifier, Puerto Rican, etc.		14. RACE — / Black, Wh	American Indian, alte, etc.		
0 5 5 4 4	BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	DATES X		NO Specif		<i>'</i>	Specify:	White		
215-0020 attending physician. ise as the burial-tra		15. DECEDENT'S EL		16e. DECEDENT'S	USUAL OCCUPATION	ON	16b, KIND OF	BUSINESS/INDI		mice	_	
- 6 -	ETED	(Specify only highest gra Elementary/Secondary (0-12)	completed) College (1-4 or 5 +)	(Give kind of v	vork done during mo	ost of working		500.11200/1110				
	4	12	2	Regist	ered N	nree		Healt!	h			
AND 2 the hospital detached to once.	COMPL	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Ma	iden Surname)				
d be	ш	William Loomi	s			Mar	v Ashby	7				
MARYLAND retained by the hospit should be detached notified at once.	TO B	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural	Route Number, City or	r Town, State, Zip				
y be n		Thomas W. McDa	nie1	227 M	acka11	St., E	1kton,	Md. 2	. 21921			
C E E E		20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Re		b. PLACE AND DATE (ame of	112/-	c. LOCATION — C		State		
MO directo		4 ☐ Donetion 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE	ICENSEE	Elkton-	Cemete	TO VADDOSCO OF SA	P P	1kton				
ALTIM death. Page funeral dire		8-1-1	noc1/			Funeral	T7	59 E.				
BA after de by the fu moval.		(Cutado	Mickey				P	lkton	, Md.	21921		
in t		23. PART i. Enter the diseases, o ahock, or heart fellure	r complicationa that cause i. List only ona cause on a	d the death. Do neach line.	not entar the mo	da of dying, aud	ch as cardiac or r	eapiratory arre	est,	Approximate interval Batwe	en	
filled i		iMMEDIATE CAUSE (Final disease or condition										
ompletely fille vi, cremation, event, the		reaulting in death)	a. Dehydlo DUE TO (OR AS	olen								
68760 ecuted with and completely burial, cremat												
5 70 - 1	CATION	Sequentially list conditions,	DUE TO (OR AS A CONSEQUENCE OF):									
P.O. BOX th certificate be e tending physician if Hygiene prior to or other traun	SAT	if any, leading to immediata cause. Enter UNDERLYING	6									
.O. BC certificate ding physicallygiene pri	Ē	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	F):							
heath certi attending mtal Hygie	CERTIFI	resulting in death) LAST	d									
S = 8 = 1	AL C	PART ii. Other eignificant condition	ona contributing to death I	but not resulting i	in the underlyin	g causa given in	Part I. 24a, WA	S AN AUTOPSY	24b. WEI	RE AUTOPSY FINDIN	GS.	
	CA				•		PEF	RFORMED?	AVA	ILABLE PRIOR TO IPLETION OF CAUSE		
RECOR requires that een signed by of Health an shows any	EDIC,						¹ U YE	S 2 70	1	DEATH?		
E 5 5 2	 M	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF	F DEATH	YES N	оп		1 '	3 1E3 2 [] NO		
TAL The law te has the are Dept.	X	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				LACE OF DEATH (CA						
	Sign	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Out	petient 3 DOA	OTHER: 4 Nursing Horn	ne 5 M Residence	6 Other (Specify))				
H = 2-	PHYSICIAN:	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. IN.	JURY AT	28d. DEŞCRIBE H	OW INJURY OCC	URED			
	ВУ	1 Accident 5 Pending Investigation				YES 2 NO						
ATTENDING ECTOR: After s after death	0	3 Suicide 6 Could not b	26e. PLACE OF INJURY building, atc. (Spe	Y — At home, term, a	street, factory, offic	•	281. LOCATION (St. City or Town, S		or Rural Route	Number,		
DIVISION OR ATTENDING DIRECTOR: After hours after death	ETEI											
	_ U		SICIAN: To the best of my know									
HOSPITAL FUNERAL WITHIN 72	СОМР	2 MEDICAL EXAMI	NER: On the besis of exemination	on and/or investigatio	n, in my opinion, c	leath occured at the	time, data end place	s, and due to the	cause(e) end	menner as stated		
TO THE HOSPI TO THE FUNER be filed within	BE (296. SIGNATURE AND TITLE OF CERTIF	ER O			29c. LICENSE NUI	MBER	29d, DATE	SIGNED (No	nth, Day, Year)		
TO THE De filed IMPOR	0	whyu				W44	102	 /	45/9	14		
		30. NAME AND ADDRESS OF PERSON Y	THO COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type,	Print)	/. [1 ,	0,	1	1-1-1	1	
		31. DATE FILED (Month, Day, Year)	SE REGISTRAR'S SIGN	///	70	WAR	DURTON	Nd	EIF	100/	70	
		DFC 0 5 '94	Julie Davidson-A	endelle								
		DEC 0 2 34	1-1-1-1-1									



1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last)

1. DECEDENT'S NAME (First, Middle, Last)

	REGISTRAN			RIIF	CAIL	UP	DEAL	П		REG. NO.			
,	MONTH DAY YEAR										. TIME OF DEATH		
- 1	Eugene F. Melavil												
	or rose (m) to rose				IF UNDER	F UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year)					8. BIRTHPLACE (State or Foreign Country)		
	066-32-1365 9e. FACILITY NAME (If not institution, give si	41	84	4 YRS. May 28,19							910 New York		
~					9b. CITY		R LOCATIO				9c. COU	NTY OF DEA	
5	V.A. Medical Cent	er				Perry Point Cecil						211	
<u> </u>	10e. STATE 10b. COUNTY	,		10c. CIT	Y, TOWN C	OR LOCAT	ION					1	Dd. INSIDE CITY
DIRECTOR	Maryland An			A	nnap	olis				1	LIMITS?		
FUNERAL	100. STREET AND NUMBER 2519 Lyon Drive		101. ZIP CODE 10g. C					10g. CITI	U.S.A.				
	11, MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	JEVER IN U.S. AR	N U.S. ARMED 2 □ NO 13. WAS DECENDENT OF HISPANIC ORIGI If yee, specify Cuban, Mexican, Puarto 1 □ YES 2 ☒ NO Specify:					n, Puarto I	t? (Specify Yee Rican, etc.)	or No-	Black, \	- Americen Indien, White, atc.
D BY	3XWidowed 4 Divorced	W.W.	II					эрвину				Specify:	White
	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Gi	CEDENT'S ive kind of v Do NOT us	vork done i	CCUPATIO during mo	ON st of workin	g		.A. Ho			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 +	•)	lical		ecto	r			atavia			k
Š	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	IER'S NAI		Middle, Maiden			
BE	Michael Mel	aville								en Bur			
2	190. INFORMANT'S NAME (Type/Print) Atelia Melaville									ber city or fowr			03
	28LT METHOD OF DISPOSITION 1 Duriel 2 Cremation 3 Remote 4 Donation 5 Other (Specify)	oval trom State	HOLY S					y 1	2/2/	94 Roc	heste	er, No	ew York
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Fun								Fune	neral Home				
	Thomas M.	tatter	DOW, o	Sr.	P	erry	vill	e, M	aryl	and 2	1903		Silie
	23. PART I. Enter the dieeeses, or cahock, or heert fellure.	omplications tha List only one ceu	t ceused the de ee on eech line	eth. Do r	ot enter	the mo	de of dyl	ng, auch	h as card	flec or reeple	ratory srr	eat,	Approximate intervel Between
	IMMEDIATE CAUSE (Fine)												Onset and Death
ı	resulting in deeth) Pneumonia												
_	DUE TO (OR AS A CONSEQUENCE OF):												
<u> </u>	Sequentially list conditions, Due to jor as a consequence of):												
¥∥	If any, leeding to immediate ceuse. Enter UNDERLYING												
Ĕ	CAUSE (Disease or injury thet initiated events	DUE TO	OR AS A CONSEC	DUENCE OF	ን:								
CERTIFICATION	resulting in deeth) LAST	l											
	PART II. Other significent condition	s contributing to	deeth but not n	eeultina i	n the un	derlylni	Celles C	dven in i	Part I	24s. WAS AN	ALITOREY	245 W	ERE AUTOPSY FINDINGS
EDICAL	Chronic Renal I						3 00000	justicui i		PERFOR	MED?	A	MILABLE PRIOR TO
	Arterioscleroti		- efe							1 X YES 2	□ NO	0	F DEATH?
PHYSICIAN: M	DID TOBACCO USE CONTR			TH VE	s 🗆 1	NO F	LINC	ERTAIN				1	☐ YES 2 X NO
<u> </u>	25. WAS CASE REFERRED TO MEDICAL	IDOIL TO CA		E OF DEAT			ONC	EKIMI	י ט ן				
SIC	EXAMINER? 1 YES 2 X NO	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER		e 5 🗆 Re	sidence	5 □ Othe	r (Snecity)			
ਵ਼ੇ ∥	27. MANNER OF DEATH	26e. DATE OF (Month, D	INJURY	28b. TIM		28c. INJ	URY AT	1		CRIBE HOW IN	JURY OCC	CURED	
84 6	1 X Natural 5 Pending 2 Accident Investigation	(MORH, D	ny, re-ur)	INJ	M		RK? 'ES 2	NO					
								te Number,					
3 Suicide 6 Could not be 4 Homicide determined Suicide, etc. (Specify) 200. PLACE OF INJUST — At nome, terms, stratet, fectory, office building, etc. (Specify) 201. Carron (Street and Number or Rural Route Number, City or Town, Stete)													
ᆲ║	299. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the ceuse(e) end manner es stated. 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(e) and manner es stated. 299. SIGNATURE AND TITLE OF CERTIFIER 290. DATE SIGNED (Month, Day, Year)												
COMPL										nd manner es stated.			
BE										lonth, Day, Yeer)			
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CALL	M	127/2==	Drint ¹		1510	094-	1		1.1	L-29-9	94
	MELECIA SANTOS, M		Medical			Per	ry Po	oint	, MD	2190	2		
	31. DATE FILED (Month, Day, Year)	JUNE DAVID	R'S SIGNATURE	2			1						
	DEC 0 1 '94	7											
													DHMH. 18. Bay 1/89

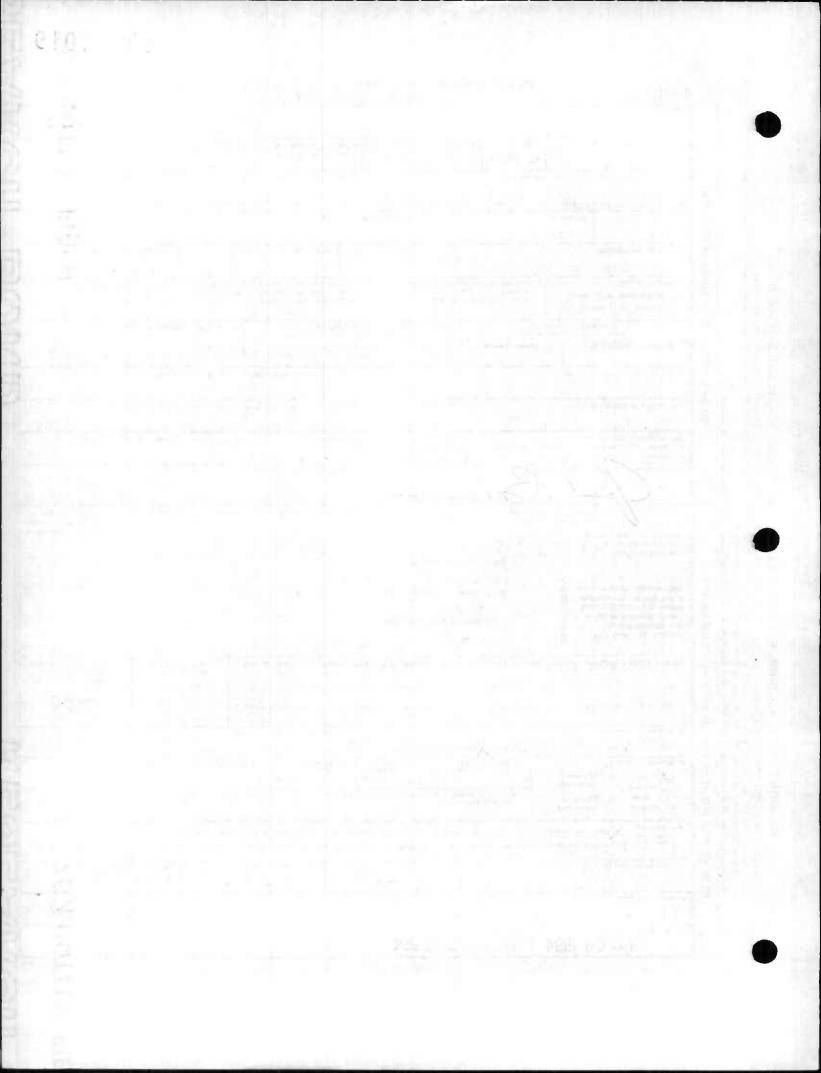
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BALTIMORE, MARYLAND 21215-0020
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O. BOX 68760,

DIVISION OF VITAL REC

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INTORING: II HOLL & I HOLL & STORE OF THE ST

	1 - FOR STATE OF MAR		MENT OF H		MENTAL HYGIENE				
	1. DECEDENT'S NAME (First, Middle, Lest) Donna W. May				2. DATE OF DEATH DAY 11-29-1		3. TIME OF DEATH		
		GE (In yrs. lest birthday) 4 7 YRS.	F UNDER 1 YEAR MONTHS DAYS	F UNDER 24 HRS. HOURS MIN. R LOCATION OF DE	7. DATE OF BIRTH (Month, Day, Year) 2-12-194	8. Bif Cod	ATHPLACE (State or Foreign unity) SSOUTI		
TOR	North Arungel Hospital	Burnie							
DIRECTOR	10e. STATE 10b. COUNTY	TATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION							
	104. STREET AND NUMBER		ZIP CODE		1 TYES 2 NO F WHAT COUNTRY?				
FUNERAL	547 Cypress Lane 11. MARITAL STATUS 1 Never Married 2 [X] Married 1 Never Married 2 [X] Married	ES 2- NO			IIC ORIGIN? (Specify Year, Puerto Rican, etc.)	ACE — American Indian, lack, White, etc.			
D BY	3 Widowed 4 Divorced IF YES, GIVE WAR O	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES					White		
LETE	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ille. Do NOT use	ork done during mos retired.)	it of working	INESS/INDUSTRY				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	16. MOTHER'S NA	Commu ME (First, Middle, Maiden S		College				
BE	40- MECONIALTO NAME CO-CO-CO	Welch		Edna					
10	19a. INFORMANT'S NAME (Type/Print) Mr. Lee May				Route Number, City or Town Severna		MD 21146		
		20b. PLACE AND DATE O cemetery, crematory or oth	FDISPOSITION (Na	me of	DATE 20c. LOC	ATION - City or	Town, State		
	21. SIGNATURE OF FUNDAL SETTINGS LICENSEE	State An	22. NAME AN	D ADDRESS OF FA		495	RitchieHwy rna PArk Ml		
		n each line. Dey coro	ot enter the mod	da of dying, auc			Approximats Interval Between Onset and Daath		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	yopat	ropathy						
CER	resulting in death) LAST								
4: MEDICAL	PART II. Other algorificant conditions contributing to deat	h but not resulting is	n the underlying	cause given in	Part I. 24a. WAS AN / PERFORI	MED?	24b. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 1 Inputtent 2 PRAY	Outpatient 3 DOA	OTHER:	ACE OF DEATH (Ch					
BY PHYS	27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, Yes) 2 Accident Investigation	RY 28b. TIME	OF 28c. INJI		e Other (Specify) 28d. DE\$CRIBE HOW IN	JURY OCCURED			
ED	3 Suicide s Could not be determined 28e. PLACE OF INJ building, etc. (c)	281. LOCATION (Street as City or Town, Stete)	nd Number or Rui	al Route Number,					
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
TO BE C	296. SIGNATURE AND TYPE OF CENTIFIER	UL m		29st LICENSE NUI	1816	29d. DATE SIGN	IED (Month, Day, Year)		
-		80 Admir	Print) Coch	vane Dr.	Annapol	1,5 M	P 21401		
	31. DATE FILED (Month, Day, Year) DEC 08 1994 32. REGISTRAR'S S	HON REVEAL							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the flow is a first death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI CERTIFIC			MENTAL HYGIEN REG. NO.	E		
	GEORGE D		MOSS	bura		2. DATE OF DEATH MONTH DATE DEATH DE	27 199	3. TIME OF DEATH	
	214-28-4323	⊠ м 2 □ F 82	YRS.		HOURS MIN.	DEC. 1, 1911	8. BIR Cou MA	PHPLACE (State or Foreign ntry) RYLAND	
TOR	99. FACILITY NAME (If not institution, give street SHADY GROVE ADVENT RESIDENCE OF DECEDENT			ROCKVII	LOCATION OF DE	ATH	9c. COUNTY OF		
DIRECTOR	100. STATE MARYLAND 10b. COUNTY MONTGOI	MERY	10c. CITY, 1 ROCK	TOWN OR LOCATION	ON			10d. INSIDE CITY LIMITS? t YES 2 NO	
FUNERAL	100. STREET AND NUMBER 14216 TRAVILAH ROAI	D			20850		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		
ВУ		FORCES? 1 X YES IF YES, GIVE WAR OR DO W. W. II	N U.S. ARMED 2 NO ATES	13. WAS DECEI If yee, spec 1 YES 2	CE — Americen Indien, ick, White, etc.				
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12)	npleted)	16e. DECEDENT'S US (Give kind of work life. Do NOT use in EXCAVATER	k done during most		CONSTRUCTION			
BE CON	17. FATHER'S NAME (First, Middle, Last) CHARLES MOS	SSBURG		N	1ARY	ME (First, Middle, Melden TRAIL			
10	MARGARET F. MOSSBU		14216 TI	RAVILAH	ROAD	ROCKVILLE,	MD. 2	0850	
	20g. METNOD OF DISPOSITION 1.29 Burlal 2 □ Cremation 3 □ Removal 4 □ Donation 5 □ Other (Spocify) 21. SIGNATURE OF FUNERAL SERVICE LICENS	from State	PLACE AND DATE OF B ARKEMAWN C	EMETERY		11/30 ROCK	VILLE,		
	> murief &	Berker)	MURIEL		ER FUNERAL		20882 SVILLE, MD.	
CERTIFICATION	23. PART I. Enter the diseases, or come shock, or heart failure. List iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	the death. Do not ach line. CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF):	fort	***	Aissau	ratory arrest,	Approximata Interval Between Onsat and Death 96 hrs	
PHYSICIAN: MEDICAL CI		- SIP ventu	ulo- partins	L Shout	cause given in	Part I. 24s. WAS AN PERFOR	MED?	Ib. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
CIAN:	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH		UNCERTAIN				
B≺	1 VES 2 NO 17 27. MANNER OF DEATN 1 S Pending 2 Accident Investigation 3 Suicide 8 Could not be	28e. DATE OF INJURY (Month, Day, Yeer) 28e. PLACE OF INJURY	28b. TIME O	Nursing Nome 28c, INJUF WORI M 1 YE	RY AT	8 Other (Specify) 28d. DESCRIBE HOW IN 28f. LOCATION (Street a	Route Number		
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: C	N: To the beet of my knowl	ledge, death occurred a	nt the time, date ea		City or Town, Stells) to the ceuse(e) end men	ner ee stated.		
TO BE C	296. SIGNATURE AND TITLE OF CERTIFICATION OF THE STATE OF	1636:	10 (Mapth, Day, Year) 27 FW						
	Samuel D. 31. DATE FILED (Month, Day, Year) NOV 2 9 1994	32 REGISTRAR'S SIGNI Julia Davidson	ATURE	6410 8	ctlodys	Dr. Beth	m, sobze	d 20817	



x 20 0

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM			ENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last,)			2	DATE OF DEATH		3. TIME OF DEATH		
	RALPH	WILLIAM Mc	KEAVER			NOV. 29	1994	4:25 P M		
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (UNDER 1 YEAR		DATE OF BIRTH (Month, Day, Year)		IRTHPLACE (State or Foreign puntry)		
	220-74-2479	1 M 2 □ F 6'	7 YRS.	NTHS DAYS	HOURS MIN.	MARCH 8,1	.927	WASH. D.C.		
~	9a. FACILITY NAME (If not institution, give		96	. CITY, TOWN O	R LOCATION OF DEAT	Н	9c. COUNTY			
DIRECTOR	8811 HAWTHORN	E CT. #103		LA	UREL		PRIN	CE GEORGES		
EC	10a. STATE 10b. COUN	ту	10c. CITY, T	OWN OR LOCAT	ION			10d. INSIDE CITY		
	MD. PR	INCE GEORGES		LAUR	EL			1 X YES 2 NO		
IAL	10e. STREET AND NUMBER			10f.	ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?		
FUNERAL	8811 HAWTHO	RNE CT.			20708		U.S.A.			
FU	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DEC	ENDENT OF HISPANIC Incity Cuben, Maxican, F	ORIGIN? (Specify Year Puerto Rican, etc.)	or No — 14. F	RACE — American Indian, Black, Whita, atc.		
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES TE		2 NO Specify	,		Specify: WHITE		
ED	15. DECEDENT'S ED	UCATION	16a. OECEDENT'S US	JAL OCCUPATIO	N .	16b. KINO OF BUS	I SINESS/INDUSTF			
COMPLET	(Specify only highest grad Elementery/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mo: tired.)	st of working			-		
MP	0		NEVER	WORKED			NONE			
8	17. FATHER'S NAME (First, Middle, Last)	T 434 34 18341			18. MOTHER'S NAME					
BE		LIAM MCKEAY				EDITH	GILLA	_		
2	19a. INFORMANT'S NAME (Type/Print) CAROL BELL	STEELD	196. MAILING AD		ITEM #10		n, State, Zip Code)		
	20a, METHOD OF DISPOSITION		.PLACE AND DATE OF D		- 11		CATION ON .	7		
	20b. PLACE AND DATE OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of the place) 20c. LOCATION — City or Town, State 2 Cremetton 3									
	21. SIGNATURE OF FUNERAL SERVICE L		?		D ADDRESS OF FACILI		DOLITIE	MD.		
	MA Ch	ambered	/ MO0091	W. W.	CHAMBERS	CO. RIV	ERDALE.	MD. 20737		
	23. PART I. Enter the diseases, or	complications that caused	the deeth. Do not	enter the mo	de ot dying, euch e	s cerdiec or reepi	ratory errest,	Approximate		
	ehock, or heert fellure. Liet only one ceuee on eech line. Intervel Batween Onset and Death disease or condition									
	disease or condition resulting in deeth) e. Congestive Heart Failure DUE TO (OR AS A CONSCOUENCE OF): Sequentially list conditions, If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DIE TO (OR AS A CONSCOUENCE OF): DIE TO (OR AS A CONSCOUENCE OF): DIE TO (OR AS A CONSCOUENCE OF):									
	DUE TO (OR AS A CONSEQUENCE OF):									
S	Sequentially list conditions, b. Atrial Fibrillahore									
AT	If sny, leeding to immediate cause. Enter UNDERLYING	Bilater	. Oles	nel	Elfer	mo		i		
Ĕ	CAUSE (Disease or Injury thet initiated events	DUE TO (OR AS A	CONSEQUENCE OF):		00					
CERTIFICATION	resulting in death) LAST	d								
	PART II. Other eigniticent condition	ons contributing to deeth b	ut not resulting in ti	he underlying	ceuse given in Per	rt I. 24s. WAS AN	AUTORSY	24b. WERE AUTOPSY FINDINGS		
CAL			at not resulting in t	ne underlying	codse given in rai	PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
PHYSICIAN: MEDIC						1 TYES 2	DIPNO	OF DEATH?		
× :	DID TOBACCO USE CON	TRIBUTE TO CAUSE O	F DEATH YES	□ NO Å	UNCERTAIN	-	i	1 YES 2 NO		
IA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEATH (ONCERIAIN					
Sic	1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp	etient 3 DOA 4	THER: Nursing Home	5 Residence 6	Other (Specify)				
H	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OI	F 26c. INJU	JRY AT 26	d. DESCRIBE HOW I	NJURY OCCURE)		
BY	1 Natural 5 Pending Investigation			M 1 🗆 Y						
<u></u>	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, atc. (Speci	— At home, farm, stree ify)	t, factory, office	26	St. LOCATION (Street a City or Town, State)	and Number or Ru	rel Route Number,		
<u> </u>	An- OCCUPIED V									
MPL		SICIAN: To the best of my knowle								
COMPLET		IER: On the basis of axaminetion	and/or investigation, in	1 my opinion, de	eath occured at the time	e, deta and placa, and	d due to the cau	ee(a) and mannar as stated.		
BE	296, SIGNATURE AND TITLE OF CHRTIFIL	ER TO			29c. LICENSE NUMBER			NED (Month, Day, Year)		
5	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED OFFICE	THE STREET		13011	1	P 12-	1-94		
	Gary W. Jone	es MD 11	365 Di-L	cea D	v. R-11	40-11-	W. J	20705		
	31. DATE FILED (Month, Day, Year)	Julia Daydon-N	TUPE 02		· Dan	an inte	TIR.	10 /03		
	DEC 0 2 1994	guia Davidson-No								

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funeral director, page 5 should be detached for use as the burial-transit Page 6 may be retained by the hospital or attending physician. completely filled in by the removal ö cremation, requires that the death certificate be executed with the attending physician and con i Mental Hygiene prior to burial, signed by the has been s Dept. of H DR ATTENDING PHYSICIAN: The law this certificate h After death DIRECTOR: A hours after d

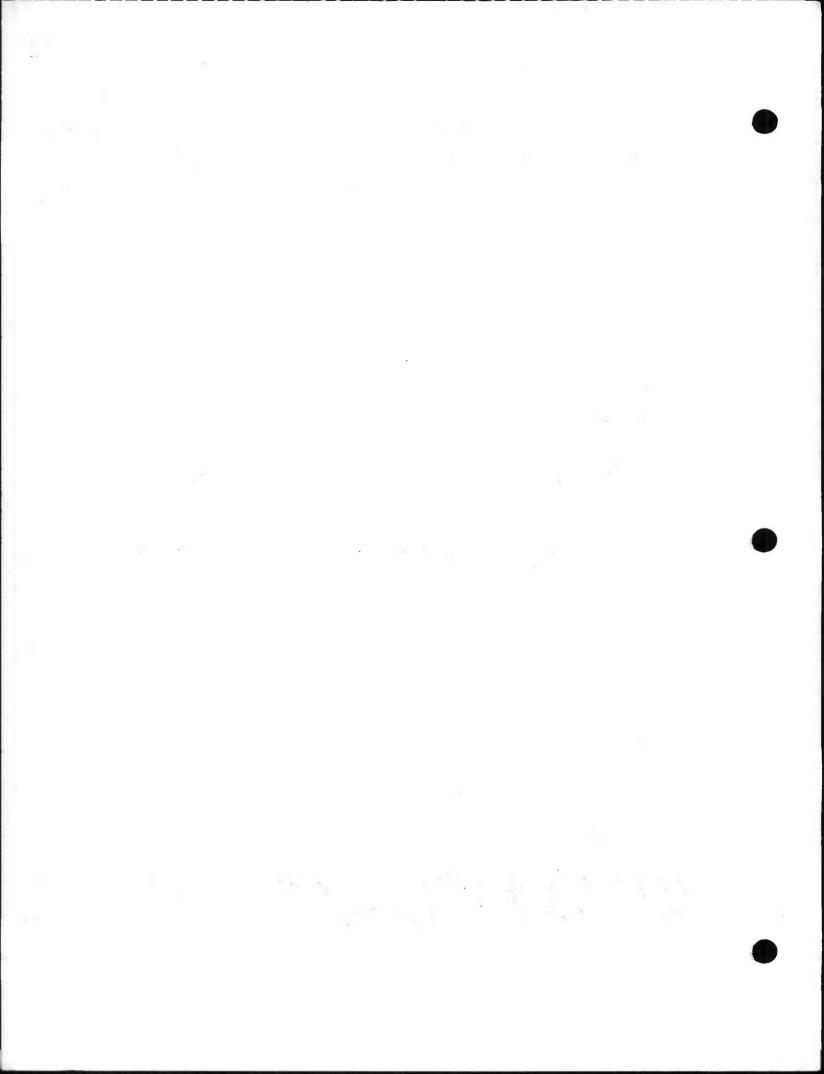
9c 11/29/AY MRT Mont 90
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE Montgomen 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. OECEOENT'S NAME (First, Middle, Last) DATE OF DEATH V8Dember Malatesta James 4. SOCIAL SECURITY NUMBER 5. SEX T. DATE OF BIRTH Q IF UNDER 1 YEAR IF UNDER 14 IME. DAYS HOURS 1 🔯 M 2 🗌 F 577-28-4435 August 19,1922 Washington, D.C 9e. FACILITY NAME (If not institution, give street and number Montgomery - Con 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 1708 Dayton Road Hyattsville. 10e. STATE 10b. COUNTY 10c. CITY TOWN OR LOCATION 1 YES 2 TO NO Prince George's Maryland Hyattsville 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1708 Dayton Road 20783 U.S.A. 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexicen, Puello Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 K Married Specify: ВУ 3 Widowed 4 Divorced WW II White COMPLETED 15. DECEDENT'S EOUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INOUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 R.E.A. Express Express Handler 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Amilio Maltesta BE Adilaide Cardinale 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ Dorothy Malatesta 1708 Dayton Road Hyattsville, Maryland 20783 20e. METHOD OF DISPOSITION
1 Street 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) 206. PLACE AND DATE OF DISPOSITION (Name of 11/29/94PATE 20c. LOCATION — Cily or Town, State Maryland Veterans Cemetery Cheltenham, Maryland 21. SIGNATURE OF FUNERIAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiretory arreat, shock, or heart fallura. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onsat and Death disease or condition THE TO (OR AS A CONSEQUENCE OF): reaulting in death) CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 TANK 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINERT HOSPITAL: 4 Nursing Home 5 Residence 6 Other (Specify) □ Inpatient 2 □ ER/Outpetient 3 □ DOA 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, etreet, fectory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, Stete) 3 Sulcide COMPLETED 8 Could not be 4 Homicide determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner se stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end menner ee stated. 296. SIGNATURE AND TITLE OF CENTIFIER 29d DATE SIGNEO (Month, Day, Year) BE

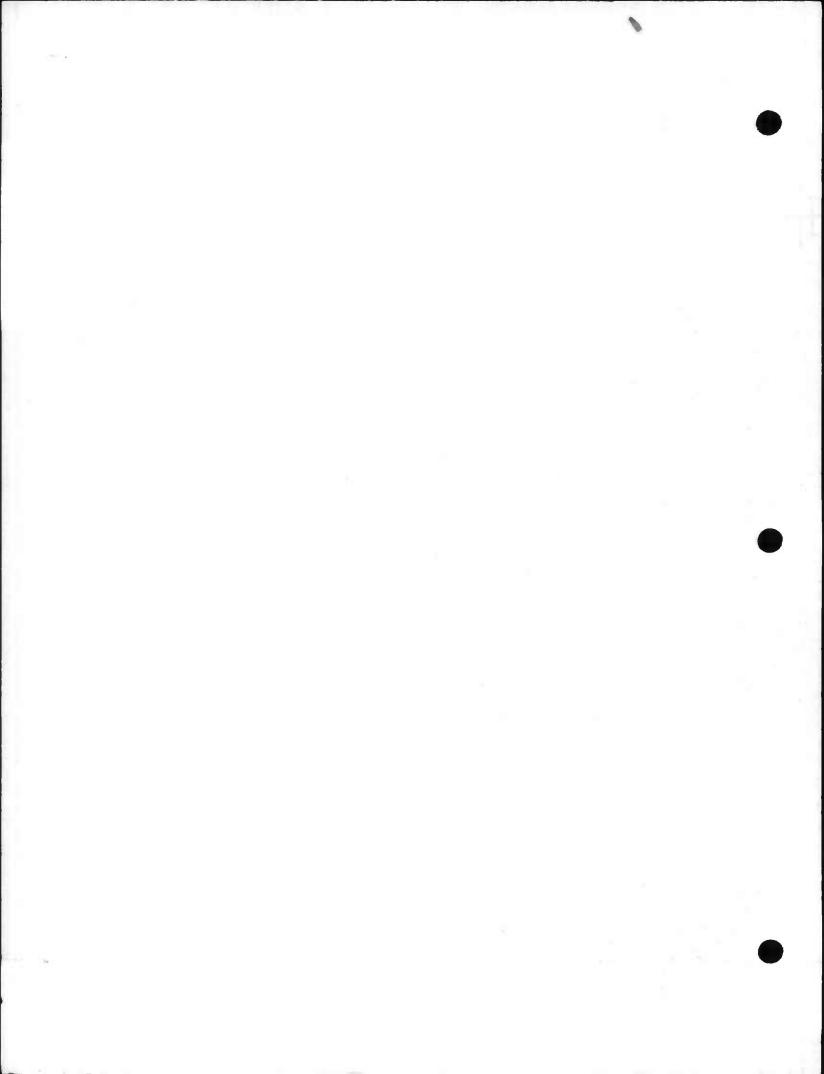
2. ARGISTRAB'S SIGNATURE/ Juna Davidson-Randelle



HOSPITAL FUNERAL within 72 h



		Amende	9	417	'//	128	194	/		0-1	Hama	94	37023	}
		FOR STATE REGISTRAR	- 4	STATE OF N	MARYL	AND / DI	EPARTIVETIC	IENT OI	F HEALTH OF DEAT	AND ME	ENTAL HYGIEN REG. NO	E	Cour	A.
	i	1. DECEMENT'S NAME (FIRST	t, Middle, Last)			ACC	14)				DATE OF OEATH	Ay	YEAR 3. TIME OF DEATH	н. Л
		4. SOCIAL SECURITY NUM	BER	5. SEX	8. AGE	(In yrs. last bir	thday) F	UNDER 1 YEA	AR IF UNDER	24 HRS. 7.	DATE OF BIRTH	66.	BIRTHPLACE (State or For	reian
20	i	579 - 36-2333		1 🔀 M 2 🗌 F	65	5	YRS. MOI	NTHS DAY	HOURS	MIN.	(Month, Day, Year) Sept. 6.]		Country) Vashington.	
3 should	œ	9s. FACILITY NAME (If not in					96	CITY, TOV	VN OR LOCATIO			-	Y OF OEATH	
2. 2.	8	Shady Grove	Adver	itist Hos	pita	1		Ro	ckvill	.e		Mo	ntgomery	
Pages	W H	10s. STATE	10b. COUNT			1	Oc. CITY, TO						10d. INSIDE CITY LIMITS?	
72	1 D	Maryland 100. STREET AND NUMBER		tgomery			Roc	kvil	10f. ZIP CODE	E		10a. CITIZE	1 ∑ YES 2 ☐ I	NO
sit	FUNERAL	13529 Gle	n Mill	. Road					208	50			ted States	
ing pt	à	11. MARITAL STATUS 1 Never Married 2 🔯 3 Widowed 4 Divo		12. WAS DECEDENT FORCES? 1 IF YES, GIVE W 1950-19	WAR OR DA	N U.S. ARMED 2 NO ATES)	If yes	DECENDENT O , specify Cubs YES 2 NO	n, Maxican, P	ORIGIN? (Specify Yas Pusrto Rican, etc.)		4. RACE — American India: Black, Whits, stc. Specify: White	in,
215 attenduse as		15. DEC (Specify on	CEDENT'S EDU	CATION a completed)		16s. DECED	DENT'S USU	JAL OCCUP	ATION most of working	10	16b. KIND OF BUS	SINESS/INDU		
.AND 2121 the hospital or atti detached for use once.	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5 + 5+	+)		NOT USE FE Physi				Mod	dicine		
AN the hos detach	ŏ.	17. FATHER'S NAME (First, N	Aiddle, Last)	31			rnysı	Clair	18. MOTE	HER'S NAME	(First, Middle, Maiden			
RYL and by the sed at	BE			ard Macor	<u>n</u>						a I. Carp			
MAR's retained 5 should notified	2	Ines Macon									te Number, City or Tow Rockville		,	
BALTIMORE, after death. Page 6 may be by the funeral director, page modal.		20g, METHOD OF DISPOSIT 1 A Burlal 2 Crematic 4 Donation 5 Other	TION on 3 - Rem	noval from State	cem	. PLACE AND	DATEOFD	ISPOSITION	N(Name of	_	DATE 20c. LO	CATION — CI	ty or Town, State	
TIM: Page rai dire	ı	21. SIGNATURE OF FUNERA		CENSEE 1/		MØ083		22, NAM	E AND ADDRES	SS_OF FACILI	my Fund	KATITE	, Maryland	_
BALTIN urs after death. Pag in by the funeral di r removal.		Darbara	-40/	McM Julk	no	SOUN	ence	Roci	kville nue, R	, Inc.	300 We	st Mo	ome/ ntgomery 20850-2805	
nours filled in b n, or rer		23. PART i. Enter the d shock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death)	naert fallura:	e. List only one ceu	I caused ise on ea	the death	NCE OF):	whey	mode of dyl	rime	es cardiac or respi	ratory arres	Approxima Interval Be Onset and	etween
Pagin and an arranged and arranged arra	ATION	Sequentially list condit if any, leading to imme cause. Enter UNDERLY	ediate	b. DUE TO	IOR AS A	CONSEQUE	Artz NCE OF):	m	Sis	Ease	-		YEars	,
P.O. B ath certificat tending phy tending phy al Hygiene p	CERTIFICATION	CAUSE (Disease or Injuthet Initiated evants resulting in death) LAS	ST T	DUE TO	(OR AS A	CONSEQUE	NCE OF):							
0/ 0 = 3	- 11	PART II. Other significa	ant condition	ns contributing to	daath b	ut not resu	ilting in ti	ha underl	ying causa g	lvan in Pai	rt 1. 24e. WAS AN		24b. WERE AUTOPSY FIN	
ECORE vires that th signed by t Health and	MEDICAL	- Dias	eter/	nellite	ک						PERFOR	1 0	AVAILABLE PRIOR T COMPLETION OF CA OF DEATH?	
RECON A requires been sign tr. of Heali		DID TOBACC	4/	CONTRIBUTE	- 70	CALICE	OF F	PEA TELL	VEC .	L NO 7	,		1 TYES 2 X N	10
	SICIAN	25. WAS CASE REFERRED T		CONTRIBUTE	: 10	CAUSE	OF L		YES	EATH (Check				
OF VITAL HYSICIAN: The law his certificate has with the State Dep	NSIC I	1 YES 2 NO		HOSPITAL:	CER/Outp	ontient 3 🗌		THER: Nursing I	Home 5 🗆 Re	sidence 6	Other (Specify)			
	PHY	27. MANNER OF DEATH 1 Natural 5	Pending	28s. DATE OF (Month, Di		20	b. TIME OF		INJURY AT WORK?		d. DEŞCRIBE HOW I	NJURY OCCU	RED	
NING Wither Seath	BÝ	2 Accident 3 Suicide	Investigation Could not be	28s. PLACE O	F INJURY	— At home,	form, atree		YES 2 _		Bf. LOCATION (Street a		Rural Route Number,	
DIVISION OR ATTENDING I DIRECTOR: After hours after death		4 Homicide	detarmined	building,	etc. (Speci	эпу)					City or Town, State)			
DIV TO THE HOSPITAL OR A TO THE FUNERAL DUFFEE De filed within 72 hours IMPORTANT: If item	COMPLETED			ICIAN: To the best of ER: On the bests of sa									csuse(s) and manner as sta	lated.
HE HO HE FUI led with	w	296. SIGNATURE AND TITLE	OF CERTIFIE	R					29c. LICE	NSE NUMBE	R	29d. DATE S	SIGNED (Month, Day, Year)	
10 D D T D T D T D T D T D T D T D T D T	면 일	30, NAME AND ADDRESS O		O COMPLETED CAUS	MD.	ATH (ITEM 27	1) /Type Ori-	7/1-	1200	5019	?	► N	W 24/199	4
354)		HARRIS M. 31. DATE FILED, MONTH, DOLL	1 KE	WER !	n.O.	. 69	10	Rock	180G	2 DR	IVE BZ	MESD	A MD 268	317
		NUV 2	8 199	4 Julia	David	ATURE ADV	ndell							



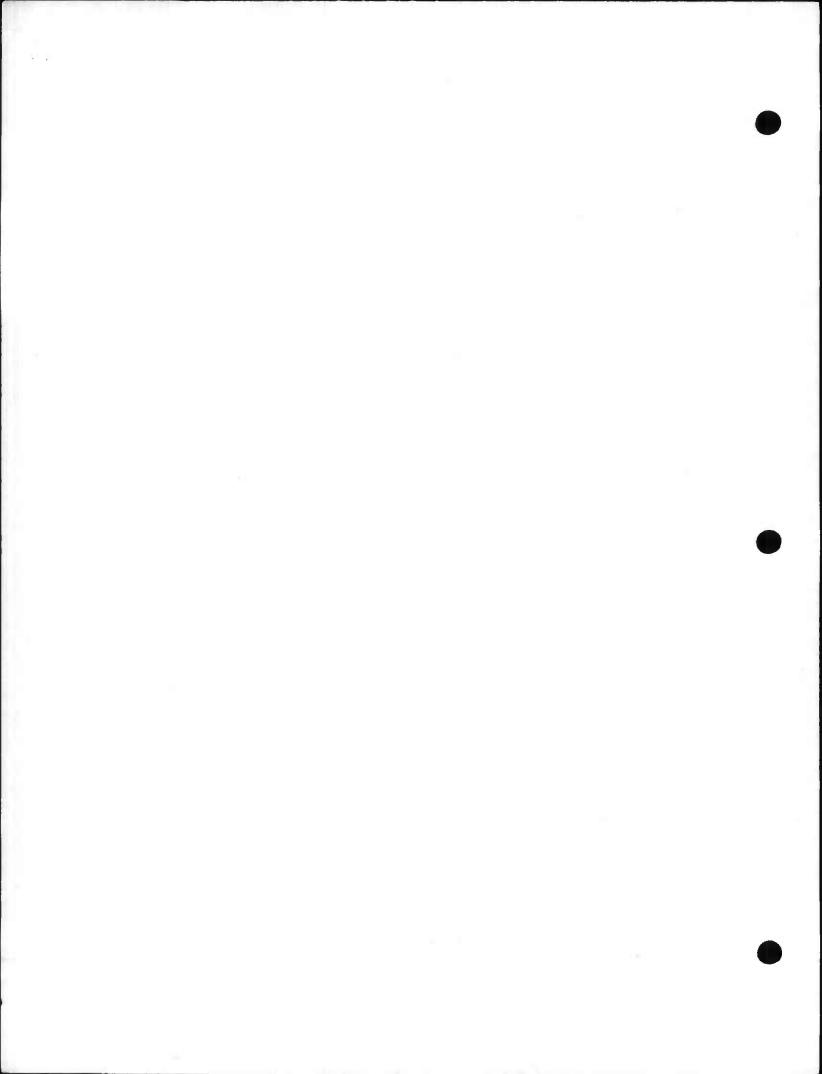
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last) Nivamte	o Devi Mehar				2. DATE OF DEATH MONTH DA	AY YEAR			
	4. SOCIAL SECURITY NUMBER		in yrs. last birthday)	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) Aug. 12,		THPLACE (State or Foreign		
1	218-39-7415	1 M 2 XF 7	1915 E	Pakistan						
	9a. FACILITY NAME (if not institution, give s			CITY, TOWN	R LOCATION OF DI					
TO	Shady Grove Adv	entist Hospit	al	Ro	ckville		Montgo	omery		
DIRECTOR	10a. STATE 10b. COUNT	Y	10c. CITY, T	OWN OR LOCAT	ION		10d. INSIDE CITY			
	Maryland Mon	tgomery		Gait	nersburg		1 YES 2 NO			
3AL	10e. STREET AND NUMBER			101	ZIP CODE		WHAT COUNTRY?			
FUNERAL	18522 Cherry La				20879			India		
B	1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 ZNO	If yea, sp	ENDENT OF HISPAI ecity Cuban, Maxica 2 NO Specif	NIC ORIGIN? (Specify Yearin, Puarto Rican, atc.)	Bla	CE — American Indian, lock, White, atc.		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18a. DECEOENT'S USI	JAL OCCUPATION	ON st of working	16b. KIND OF BUS	SINESS/INDUSTRY			
Ē	Elementary/Secondary (0-12)									
MC	17. FATHER'S NAME (First, Middle, Last)		18 MOTHER'S NA	ME (First, Middle, Maiden	Own Hom	ne				
	Kanshi Ram San	J				lan Devi	Surname)			
0 BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	ORESS (Street a	nd Number or Rural	Route Number, City or Tow	n, State, Zip Code)			
F	Dinesh K. Mehar						hersburg	, MD 20879		
	20a. METHOD OF DISPOSITION 1 Burial 2 Commation 3 Ram	ovel from State 20b	PLACE AND DATE OF D etery, cremetory or other	plece) NOV	me o26, 19	94 OATE 20c. LO	CATION — City or			
	4 Donation 5 Other (Specify) 21. SHOMATUBETOF FUNERAL SERVICE LIE		lontgomery	22. NAME AR	OTIUM,	Lnc. Beti	nesda, M	aryland		
	Raluf &	out	M00198	Robert 7557 v	A. Pum hesda-Cl Visconsin	phrey Funer nevy Chase, n Ave.,Beth	ral Home , Inc. nesda,MD	20814-3501		
	23. PART i. Enter the diseases, or shock, or heart failure.	complications that caused List only one cause on e	tha death. Do not sch iina.	entar tha mo	da of dying, suc	h as cardiac or reapi	ratory arrest,	Approximata Interval Between		
	IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ACUTE Myocandicul infarction Onset and Death 30Min									
	resulting in death)	a. // C // 7.5	CONSEQUENCE OF):	prolin	il out	pretion		30 Min		
z	COLDAN BALLIN DISCUSSE 3 VE									
RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR ASA	CONSEQUENCE OF):) "						
	CAUSE (Disease or injury CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF):									
	resulting in death) LAST	diat initiated evalue								
S	PART II. Other aignificant condition	a contributing to death h	ut not resulting in t	he underlying	cause alvan in	Part I. 24a. WAS AN	ALITOPON LA	No. WERE AUTOPSY FINDINGS		
Z			at not resulting in t	na onoanyn	Cauda givan in	PERFOR	IMED?	AMAILABLE PRIOR TO COMPLETION OF CAUSE		
MEDIC						1 TYES 2	3c, NO	OF DEATH?		
	DID_TOBACCO_USE	CONTRIBUTE TO	CAUSE OF D	EATH Y	ES NO) प्रि				
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	100	26. PL THER:	ACE OF DEATH (Ch	eck only one)				
HYSICIAN:	1 TYES 2 TYNO 27. MANNER OF OEATH	1 Inpatient 2 FR/Outp		Nursing Hom		8 Other (Specify)				
۵.	1 Natural 5 Pending	(Month, Day, Year)	INJURY	WO	RK?	28d. DEŞCRIBE HOW II	NJURY OCCURED			
D BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY building, etc. (Spec	— At home, farm, strai			281. LOCATION (Street a City or Town, State)	and Number or Rura	I Route Number,		
COMPLETED	4 Homicide determined					Only or nown, orang				
AP.		ICIAN: To the best of my know								
00	2 MEDICAL EXAMINE	ER: On the basis of examination	n and/or investigation, is	n my opinion, d	eath occured at the	time, data and place, an				
BE	29b. SIGNATURE AND TITLE OF CERTIFIE) 44 D		29c. LICENSE NUI	MBER	29d. DATE SIGNE	ED (Month, Day, Year)		
2	30. NAME AND ADORPSS OF PERSON WH	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Pri	nt)	41/9	41	NONE	EARHAP 25,1894		
	9901 M.	solicul CE	wten 1	Dr. 12	achuil	1-10d	200	50		
	31. DATE FILED (Month, Pay, Year)	32. REGISTRAR'S SIGN	ATURE Randale			- 111.63	~ ~ ~			
	11016813	Jan January	101-10-10	-						



BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

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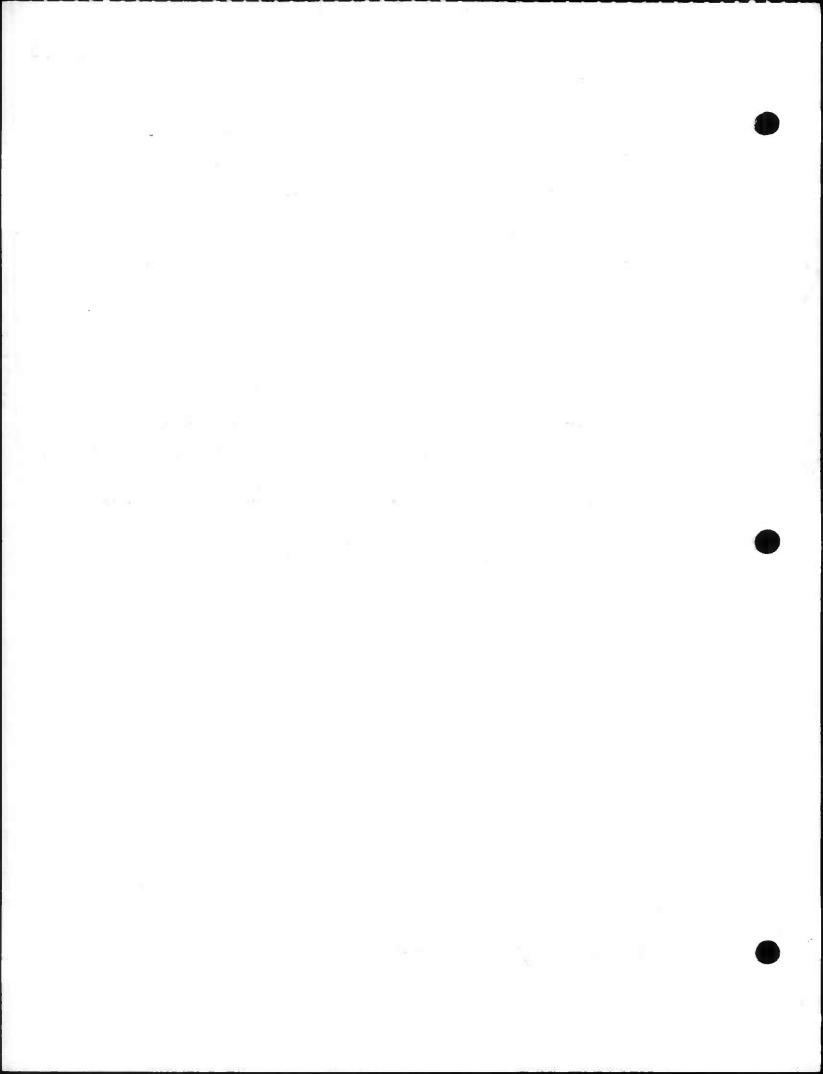
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM			MENTAL HYGIEN	E		
1. DECEDENT'S NAME (First, Middle, I	Last)				2. DATE OF DEATH		3. TIME OF DEATH	
Bertha	R.	Myers			NOV. 24,		6:30 p M	
4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BURTH	a pipi	MDI ACE (State or Foreign	
213-11-1618	1 - M 2 M F 7	7 YRS.	ONTHS DAYS	HOURS MIN.	(Month, Day, Yoar) Jan 25,	1917 Ma	ryland	
9a. FACILITY NAME (If not institution,		91		R LOCATION OF DE	ATH	9c. COUNTY OF		
116 Wesley A			Cato	2	Baltimore			
RESIDENCE OF DECEDENT		10c. CITY. T	OWN OR LOCAT	ION			10d, INSIDE CITY	
Maryland Ba	altimore		tonsvi				LIMITS?	
10e. STREET AND NUMBER	IITIMore	<u></u>		ZIP CODE		10n, CITIZEN OF	1 1 NO NO WHAT COUNTRY?	
116 Wes	lev Ave.			21228		U.S.		
11. MARITAL STATUS	12. WAS DECEDENT EVER I	N U.S. ARMED	13. WAS DECI	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yes		CE — American Indian,	
1 Never Married 2 Married	FORCES? 1 YES	2 NO	If yes, spe	cify Cuban, Maxica	n, Puarto Rican, alc.)	Ble Spe	ck, White, alc.	
3 XWidowed 4 Divorced	21 220000000000000000000000000000000000		1	X (vo apacin)		Ë	lack	
15. DECEDENT'S (Specify only highest	EDUCATION grade completed)	16a. DECEDENT'S US (Give kind of work	UAL OCCUPATIO	N at of working	16b. KIND OF BUS	INESS/INDUSTRY		
Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re	etired.)	a warming				
12th Grade		Hous	<u>ewife</u>		Non	ne		
17. FATHER'S NAME (First, Middle, Las	,				ME (First, Middle, Maiden			
Frank	Thompson				trude	Ridec	ut	
19a. INFORMANT'S NAME (Type/Print)	(5011)				Route Number, City or Town			
Mr Bernard	Myers				Catonsvil			
20a, METHOD OF DISPOSITION	Ramoval from State Car	petary, crematory or other	DISPOSITION (Nat place)	me of	.11/29 La	CATION City or 1	own, Stata	
4 Donation 5 Other (Specify)	PTICENSEE /	Maryland		DADDRESS OF FA		urel,M	ld	
) //	/			neral Hor	10 D 7	20950	
DL042 1	. Onou	den						
23. PART I. Enter the diseases,	, or complications that cause ure. List only one cause on e	d the deeth. Do not	enter the mod	de of dying, suci	h es cardlec or reepl	ratory arrest,		
IMMEDIATE CAUSE (Final	- 1		ti. La	ch.	1.		Onset and Desth	
diseese or condition resulting in death)	ONISCH	2 Kals	lure	- gran	tenzou	5	1-0	
	DUE TO OR AS	CONFEORENCE OF	min	el with	Perito	hitis	1 2 2003	
Sequentially list conditions,		CONSEQUENCE OF	1	Tust	thorace	, - / / 3	Ch 11	
if any, leeding to immediate cause. Enter UNDERLYING			0164	21,191	11/0.		6 months	
CAUSE (Disease or Injury	C. IUM	SONSECHENCE DE):	7175					
that initisted eventa resulting in deeth) LAST	(3) 52h	Sis					5 Days	
							13.	
PART II. Other eignificant cond	Itions contributing to death i	out not resulting in t	the underlying	ceuse given in	Part i. 24s. WAS AN PERFOR	AUTOPSY 24	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
					t _ YES 2	//	COMPLETION DF CAUSE OF DEATH?	
			4			*	1 TYES 2 NO	
DID TOBACCO USE CO	NTRIBUTE TO CAUSE C	F DEATH YES	□ NO 🗹	UNCERTAIN	10			
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH						
1 - YES 2 - 40	HOSPITAL: 1 Inpatient 2 ER/Out		THER: Nursing Home	5 Realdenca	8 Other (Specify)			
27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O			28d. DESCRIBE HOW IP	JURY OCCURED		
1 Natural 5 Pending 2 Accident Investigat				ES 2 ND				
3 Suicide 6 Could no	building, atc. (Spe	f — Al home, farm, stree	et, factory, offica		28f. LOCATION (Street a City or Town, State)	nd Number or Rural	Route Number,	
4 Homicide detarmine	rd .							
29a. CERTIFIER Check only	PHYSICIAN: To the best of my know	riedge, death occurred s	t the time, data	and place, and due	to the cause(a) and man	ner as stated.		
one) 2 MEDICAL EXA	MINER: On the busin of examination	n and/or investigation, i	n my opinion, de	eath occured at the	time, data and placa, and	dua to the cause	(a) and manner as stated.	
296 EIGNATURE MET TITLE OF COM	man U A	14 1		29c. LICENSE NUN	IBER	29d. DATE SIGNE	(Morth, Bay, Wast)	
0100	/ray/	MU,		DO	777	· ///	25/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Agint)								
1303 F	rederick	159 6	ston	5 VI/1 2	9 2122	e my		
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN			111	4100			
NOV 2 x 199	4 Julia Davidson	- Randell						



TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Amended: FOR STATE REGISTRAR		7 STATE OF N	1/30/90 MARYLAND I	/ DEPARERTIE	MR7	OF HEALT	Mon H AND I	MENTA	OJ OW NY HYGIEN REG. NO	94 ner	3	1826
1. DECEDENT'S NAME (First, Midd Anne Levine M		ochan						MON			YEAR 3.	TIME OF DEATN
4. SOCIAL SECURITY NUMBER	icoec	5. SEX	8. AGE (In yrs. la.	at histholms	IF UNDER 1 Y		DER 24 HRS.	_	16, 19			:10 P. M
034-05-7323		1 M 2 TF	79	YRS.		AYS HOUR	-	(Mor	nth, Day, Year)		Country)	ACE (State or Foreign
9e, FACILITY NAME (If not institution	on, give str			15314	9b. CITY, TO	OWN OR LOC	ATION OF DE		6, 19	Pe. COUNT		chusetts
Circle Manor	Nurs	ing Home	j			ingtor				Monta		
RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIGE CITY												
												INSIDE CITY
Maryland M	10nto	omery		S1.	lver S	pring	ODE			10a CITI75		YES 2 NO
3330 North Le	eisur					2090	06			USA		COONTRY?
11. MARITAL STATUS 1 Never Merried 2 Marri 3 Wildowed 4 Divorced	led	12. WAS DECEDEN FORCES? 1 IF YES, OIVE W	T EVER IN U.S. AF YES 2 TAR OR OATES	NO	If y	S DECENDEN BB, specify Co YES 2 (2).1	ıban, Mexica	n, Puarlo	IN? (Specify Yes Rican, etc.)	s or No— 1	Black, V Specify:	American Indien, white, etc.
15. DECEDEN (Specify only high			10	inn kind of	USUAL OCCU	JPATION ng most of wo	rking	16	b. KIND OF BU	SINESS/INDU	STRY	
Elementary/Secondary (0-12)		College (1-4 or 5 a	-) life	. Do NOT u	se retired.) tologi				Fashior	n Indu	stry	:
17. FATHER'S NAME (First, Middle,	Last)								Middle, Maiden	Sumame)		
	Henry Levine Rebecca Openden											
Philip P. McG		an	19	3330	N. Le	isure	World	BO1	nber, city or fow ulevar	n, State, Zip C	ver S	Spring MD
20e. METNOD OF OISPOSITION 1		val from Stata	20b. PLACE cemetery, cre Arlin	and date ematory or o	of disposition of the place in Natio	nal Ce	emeter	од y11,	TE 20c. LO	cation - ci	or Town	State /A
21. SIGNATURE OF FUNERIAL SER	L I	Rasen							eral Di			4D 20852
23. PART I. Enter the disease abock, or heart IMMEDIATE CAUSE (Final disease or condition resulting in death)	or co	ary	t csused the dese on each line	non	buts							Approximata interval Batwean Onset and Daeth
Sequantially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			(OR AS A CONSE									
multi e	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PERFORMED? 1 YES 2 NO											
DID TOBACCO USE (IROLF IO CY			TN (Check only		ICERTAIN	<u>ч Ц</u>				
EXAMINER?	-	HOSPITAL:			OTHER:		0.14		<i>(</i> 0			
27. MANNER OF DEATN 1 Natural 5 Pendi	ing	28e. DATE OF (Month, Da	INJURY	28b. TIM	E OF 28	c. INJURY AT WORK?			er (Specify) ESCRIBE NOW I	NJURY OCCU	RED	
3 Suicida 8 Could 4 Nomicide determ		28e. PLACE Of building,	F INJURY — At ho artc. (Specify)) ome, term,				28t. LO	CATION (Street a y or Town, State)	and Number or	Rural Rout	e Number,
29e. CERTIFIER					Contract of the							

D. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2770/ype, Print)

JEANNE P. ASHER MD 3730

730 FARRAGUT AVE KENS

KEN SINGTON MD. 20895

NOV 2 1 1994 Julie Deutson Ander

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	. OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within servicus; after death, Page 6 may be instained by the hospital or attending physici	DRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the user as the burst
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

anding physician. as the buria-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law nequins that the death certificate be executed within excitours after death. Page 6 may be retained by the host TO THE FUNERAL DRECIDE After this certificate has been signed by the attending physician and completely filted in by the funeral director, page 5 abound be detained by filter and Mental Hygiene prior to burst, crimitation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC	MENT OF I	IEALTH AND	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	MV VE	3. TIME OF DEATH		
	GUS 4. SOCIAL SECURITY NUMBER		RMAGAS (In yrs. last birthday)	IMPER A MEAN		Nov. 25,	1994	1:40 Pm		
	579-66-0915 9a. FACILITY NAME (If not institution, give st	1 [X M 2 □ F	55 YRS.	UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		1939 g	BIRTHPLACE (State or Foreign Country) PERCE		
TOR	Wellington Manor			Clint	OR LOCATION OF D	EATH	9c. COUNTY	of DEATH Ce George's		
DIREC	10a. STATE 10b. COUNTY	1	10c. CITY, T Wash	<u> </u>	10d. INSIDE CITY LIMITS? 1 X YES 2 NO					
AL	10e. STREET AND NUMBER				10g. CITIZEN	OF WHAT COUNTRY?				
VER	1439 Northgate Ro	oad, NW	2	0012		Greed	ce			
BY FUNERAL DIRECTOR	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	N U.S. ARMED 2) NO ATES	Il yes, sp	ENDENT OF HISPA ecity Cuban, Mexico 2/17/NO Specific	NIC ORIGIN? (Specify Yean, Puerto Rican, etc.) fy:		RACE — American Indian, Black, Whita, atc. Specify: White		
ED	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S USI	JAL OCCUPATION OF THE COMPANY	ON set of working	16b. KIND OF BU	SINESS/INDUST			
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	Head Wai	tired.)		Restau	rant			
ゑ	17. FATHER'S NAME (First, Middle, Last)		71000 1102	001	18. MOTHER'S NA	AME (First, Middle, Maider				
BE	Gregory Marmaga	as			Panagi		/ailable			
2	19a. INFORMANT'S NAME (Type/Print) William G. Marma	agas				Route Number, City or Tow e. #201. F				
	20a. METHOD OF DISPOSITION 1 (V) Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Company of other place)									
	4 Donation 5 Other (Specify)		ort Lincol	V -	tery ID ADDRESS OF FA		ntwood,	Maryland		
	· Ellen	XI. Ra	20	Rapp	Funeral	Services,				
	23. PART i. Enter the diseases, or cahock, or heert fellure.	complicatione that caused List only one cause on e	the deeth. Do not ach line.	anter the mo	1ST AVER	th as cardiac or resp	iratory arreat,	Approximate interval Between		
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	B DUE TO (OR AS A	CONSEQUENCE OF:					Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in deeth) LAST									
AL C	PART ii. Other eignificant condition	e contributing to deeth b	ut not resulting in t	he underlyin	cause given in	Part i. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS		
200						1 _ YES	IIIICD1	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	DIRLITE TO CALISE O	E DEATH VEC		UNCERTAI			1 - YES 2 X NO		
NAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (UNCERIAII	N L]				
YSIC	1 □ VES 2 € 10	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Oulp		HER:	e 5 🗆 Rasidenca	8 Other (Specify)				
ВУ РН	1 About 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O	M 1 🗆	RK? 'ES 2 NO	28d. DEŞCRIBE HOW	INJURY OCCURE	D		
8	3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY building, etc. (Spec	— At home, farm, stree (fy)	t, lactory, offic		28t. LOCATION (Street City or Town, State	and Number or Ru	ural Route Number,		
COMPLET		CIAN: To the best of my know R: On the basis of examination						use(a) and mannar as stated.		
TO BE (29h. SIGNATURE AND TITLE OF CERTIFIER	0	nD		D20		mber 25, 1994			
	Jeffrey A. Kelmar	COMPLETED CAUSE OF DE			08. Hvat	tsville, M	D 2078	32		
	31. DATE FLED (Month, Day, Year)	32. REGISTRAR'S SIGN.	ATURE		, , , , - ,					
	WUV Z 8 1994	Julia Davidson	n-Mandell					DHMH-16 Rev 1/89		



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	The offer death Dags & m
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	one that the death cardificate he executed with
R	COMME
VISION OF VITAL RE	ATTENDING DUVEICIAN: The law cook

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Cours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fined within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

MC, USNR

Julia Davidson Randell

TARA L. LORENCE, LT,

31. DATE FILED (Month, Day, Year)

	iddle, Last)	CONNOR	MALI	IK MCCA	RTY				2. DATE OF DEATH MONTH NOV 27	1994	YEAR 3	TIME OF OEATH P
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In	yrs. lest birthday)		R 1 YEAR	IF UNDER		7. DATE OF BIRTH (Month, Day, Year)		B. BIRTHPL Country)	ACE (State or Foreign
220-41-3394		1 M 2 F		YRS.	4 4	15	HOURS	MIN.		1994		land
9a. FACILITY NAME (If not instit	ution, give str	eet and number)			9b. CIT	Y, TOWN C	OR LOCATION	ON OF DE	ATH	9c. COUN	TY OF DEA	тн
National Nav		dical Cer	nter		Be	ethes	sda			Mon	tgome	ry
	Ob. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	TION				1	Od. INSIDE CITY
Maryland	Anne	Arundel		Fo	ort N	1eade	2				1	LIMITS?
10e. STREET AND NUMBER						101	ZIP CODE	E	- 1	10g. CITI	ZEN OF WH	AT COUNTRY?
2684B Buckn	er Roa	ad					2075	55		Uni	ted S	States
11. MARITAL STATUS		12. WAS OECEDENT FORCES? 1	EVER IN U	S. ARMEO	13.				IIC ORIGIN? (Specify Yen, Puerto Rican, etc.)	s or No—	14. RACE -	- American Indian, White, atc.
1 X Never Merried 2 Miles Mile		IF YES, GIVE W					2X NO					African
15. DECED	ENT'S EOUC	ATION	1	6a. DECEDENT'S	LISUAL C	CCUBATIO	DM .		16b, KIND OF BU	EINESS (INC	Amer	ican
(Specify only hi	ghest grade o	completed)		(Give kind of life. Do NOT u	work done	during mo		ng	166. KIND OF BU	SINESS/INU	USINT	
O	'	College (1-4 or 5+	'	No	ne				No	one		
17. FATHER'S NAME (First, Midd	le, Last)						16. MOTI	HER'S NA	ME (First, Middle, Maiden	Surname)		
Billy J. Mc	Carty						D	eWan	a D. Hughe	es		
19a. INFORMANT'S NAME (Type	/Print)								Route Number, City or Tox			
Billy J. Mo	Carty		1		_				ort Meade,	Mary	yland	20755
20e. METHOD OF DISPOSITION		val from State	20b. Pi	LACE AND DATE	OF DISPO	SITION (Ne	ome of 12	/2/9	4 DATE 20c. LC	CATION -	City or Town	n, Stata
4 Donation 5 Other (S	migration or market	1		lington	Nat	iona	1 Ce	mete	ry Ar	lingto	on, V	irginia
21. SIGNATURE OF FUNERAL I	124	herin	0	M0084	6 R C B	ober hevy ethe	Cha sda,	Pum Se, Mar	phrey Fune Inc., 7557 yland 208	eral Misc Wisc 314-35	Home/	Bethesda- n Avenue
23. PART / Enter the disease or condition resulting in desth) Sequentially list condition if any, leading to immedia. Enter UNDERLYING CAUSE (Disease or injury	a a b.	COMPI OUE TO	ICAT OR AS A C	IONS FR ONSEQUENCE O	OM S					iratory arr	eat,	Approximate interval Between Onset and Daath
that initiated events resulting in death) LAST	l d	DUE TO	OR AS A C	ONSEQUENCE O	F):							
PART II. Other algorificant	conditions	contributing to	death but	not resulting	in the u	nderlying	g cause (given in	Part I. 24a. WAS AN PERFO! 1 YES :	RMED?	C	RERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO
25. WAS CASE REFERRED TO I	MEDICAL				-	26. PL	ACE OF D	EATH (Ch	eck only one)	_		
EXAMINER?		HOSPITAL:	FR/Outpati	ent 3 🗍 DOA	OTHE	R:						
27. MANNER OF DEATH	nding	26a. DATE OF (Month, Da	INJURY	25b, Till	_	28c. tNJ WO	URY AT		6 Other (Specify) 28d. DESCRIBE HOW	INJURY OCC	CUREO	
1 Natural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be determined determined control of the determined cont												

NATIONAL NAVAL MEDICAL

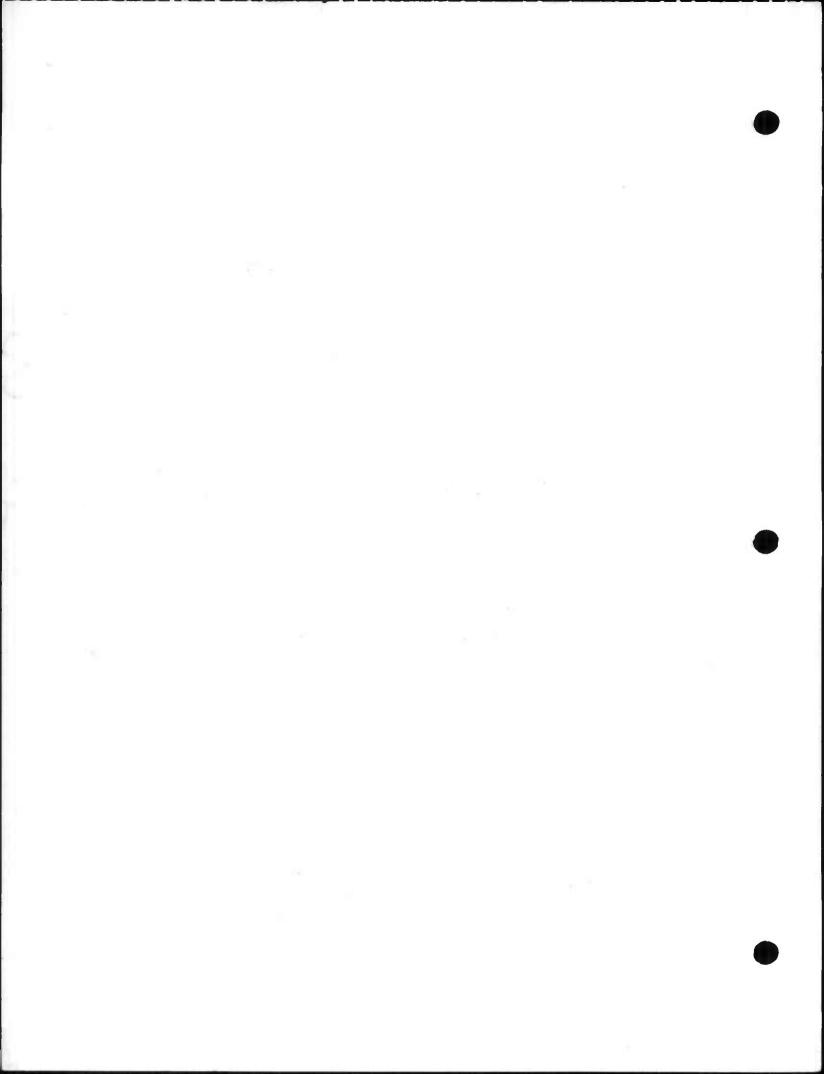
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MARYLAND	
BALTIMORE,	
58760	

DIVISION OF VITAL RECORDS, P.O. BOX 6

TO THE HDSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF I		MENT	AL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)						TE OF DEATH		3.	TIME OF DEA	ATH
	William Armitage M	illiron				No	ov. 29		AR)4	4:4	5 pM
			n yrs. lest birthdey)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		E OF BIRTH onth, Day, Year)		BIRTHPLA Country)	CE (State or I	Foreign
	272 07 3733	X M 2 □ F	86 YRS.			Ju	ly 25, 1	908		Ohio	
~	9e. FACILITY NAME (If not institution, give street				OR LOCATION OF O	EATH		9c. COUNTY			
DIRECTOR	Rockville Nursing	Home		Roc	kville			Mont	gome	ery	
REC	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION				100	I. INSIDE CIT	Υ
ā		ntgomery		Kensing	ton				1 [YES 2 🛚	NO
FUNERAL	104. STREET AND NUMBER			10	I. ZIP CODE	0.5		10g. CITIZEN			
NE I	3916 Dunnell Lane	. WAS DECEDENT EVER IN	IIS ADMEO	12 WAS DE	208		MAIS (Consider Mos	Unite		ates	100
	1 Never Merried 2 Merried	FORCES? 1 YES	2 X NO	It yee, sp	ecity Cuben, Mexico	en, Puert	o Ricen, atc.)	OF NO.	Black, Wi	American inc hite, etc.	llen,
ВУ	3 Widowed 4 Divorced			1	Z Z NO Specific	·y				Vhite	
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade com	ON apleted)	16a. DECEDENT'S (Give kind of life. Do NOT u	USUAL OCCUPATION ork done during me	ON est of working	10	6b. KIND OF BUS	INESS/INDUST	RY		
PE	Elementary/Secondary (0-12) C	college (1-4 or 5+)		ry/Trea	nurar	D	cofing	s. Choot	- Mot	-01 Co	mnont
MO	17. FATHER'S NAME (First, Middle, Last)	-4	pecieta	ily/ilea	18. MOTHER'S NA				Met	ar co	mpany
BE C	Samuel Cloyd Milli	ron			Mae Arı						
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street	and Number or Rural		~	7, State, Zip Coo	fo)		
F	Mary Lou Hudtloff		3916	Dunnell	Lane, K	ensi	ngton,	Maryla	ind 2	20895	
	20e. METHOD OF DISPOSITION 1 Burlel 2 □ Cremation 3 □ Removal	from State come	etery cremetons or	OF DISPOSITION (Nather plece)				CATION — City			
	4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSE	TC SEE	odd Memo	rial Cem	etery 12	2/3/9	Povol	ungsto	wn,	Ohio_	
i	7.51	7			East Dee:				11 110	ome	
-4	23. PART I. Entar tha diaegsea, pr com	policetions that caused	the death Do	Gai	thersbur	g, M	D 20877	7			
	ahock, or heaft fallura. List	Dnly Dna causa Dn as	ich Ilna.	iot ailtar tile int	da Di dying, auc	cn as ca	rollic or ralapi	ratory arreat,		Approxin	Between
	IMMEDIATE CAUSE (Final disease or condition	renal failu	ro							Onset an	
	resulting in death) a	DUE TO (OR AS A		F):	<u></u>					mont	-11
Z	Sequentially list conditions, b.	cardiac aar	rhythmia	a						year	s
ATK	if any, leading to immediate	DUE TO (OR AS A		F):							
임	CAUSE (Disease or Injury that initiated evants	arterioscle DUE TO (OR AS A		F):						year	S
CERTIFICATION		chronic con	gestive	heart f	ailure					year	s
	PART II. Other significant conditions of	ontributing to death bu	ut not rasulting	in the underlyin	g cause givan in	Part I	24a, WAS AN	ALITOPSV	245 WE	RE AUTOPSY	EINDINGS
CAL					g could given in		PERFOR	MED?	AWA	ILABLE PRIOR	OT 9
百							1 TYES 2	X NO		DEATH? YES 2 3	NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB	UTE TO CAUSE O	F DEATH YI	S NO [UNCERTAI	N \square			• -	J 123 2 Q	
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	28. PLACE OF DEA	TH (Check only one) OTHER:							
YSI	1 TYES 2 XNO 1	Inpetient 2 ER/Outpe		4 K Nursing Hon	e 5 🗆 Reeldence						
	27. MANNER OF DEATH 1 ☑ Natural 5 ☐ Pending	26e. DATE OF INJURY (Month, Day, Year)	28b. TIN		PRK?	28d. D	EŞCRIBE HOW IN	IJURY OCCUR	ED		
BY	2 Accident Investigation 3 Suicide & Could not be	26e. PLACE OF INJURY	- At home, term,			281. LC	OCATION (Street a	nd Number or F	lural Route	Number	
三	4 Homicide 6 Could not be determined	building, atc. (Speci	ify)			Cit	ty or Town, State)				
PLE	29e. CERTIFIER (Check only 1 X CERTIFYING PHYSICIAN	N: To the best of my knowle	edge, death occurr	ed at the time, date	end plece, end due	e to the c	cause(e) end men	ner ee atated.			
COMPLETED	one) 2 MEDICAL EXAMINER: O								use(e) en	d menner ee	stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	1 1	1 0	1.0	29c. LICENSE NU	MBER		29d. DATE SIG	GNED (Mo	nth, Day, Yeer)
10 B	Frankl	WWHI	hal	MO	D19	78	5	Nove	mber	30,	1994
	30. NAME AND ADDRESS OF PERSON WHO CO										
- #	Frauke Westphal, M. 31. DATE FILED (Month, Day, Year)	.D. 809 Vie:		Road #10)1, Rock	vill	e, MD 2	0851-1	689		
	DFC 0 1 1994	Luna Davids		<u> </u>							
	11 1 1 1 1007	1			-					DHMH	16 Rev 1/89



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10е 6 п	lirector,		r mus
d within 24 hours after death. Page 6 may be retained by the hospital	uneral (other traumatic event, the medical examiner must b
after de	y the funeral	noval.	cal ex
hours	d nl be	Of ren	med
thin 24	stely fill	mation	rt, the
nted will	comple	ial, cre	E even
e execu	an and	to bur	umati
ficate b	nding physicia	ne prior	er tra
th certif	ending	Hygier	or oth
he dear	the aft	Mental Hy	njury,
s that t	ned by	of the and	any
require	een sig	of Hea	shows
he law	has b	B Dept.	n 23
ICIAN: The	rlificate	the State Dept. of Health and	1, or Item 23 shows any in
PHYSIC	this cert	with th	rked,
NDING	: After	r death	is ma
THE HOSPITAL OR ATTENDING PHYSICI	THE FUNERAL DIRECTOR: After this	e filed within 72 hours after death with	MPORTANT: If Item 28 is marked,
TAL O	RAL DI	72 hox	: If Ite
E HOSE	E FUNE	d within	RTANT
E C	THE	e file	MPO

3. TIME OF DEATN 2:30 P THPLACE (Stelle or Foreign norty) Sachusetts DEATH OMERY 10d. INSIDE CITY LIMITS? LIMITS? VES 2 NO TWHAT COUNTRY? States CE — American Indian, sek, White, etc. Body: White
1 2:30 P THPLACE (State or Foreign only) Sachusetts DEATH OMERY 10d. INSIDE CITY LIMITS? LIMITS? LYES 2 NO WHAT COUNTRY? States CE—American Indian, sock, White, etc.
THPLACE (State or Foreign nity) Sachusetts DEATH OMERY 10d. INSIDE CITY LIMITS? 14 YES 2 NO WHAT COUNTRY? States CE — American Indian, seck, White, etc.
DEATH OMERY 10d. INSIDE CITY LIMITS? 11 YES 2 NO FWAT COUNTRY? States CE — American Indian, lock, White, etc.
OMERY 10d. INSIDE CITY LIMITS? LIMITS? VES 2 NO WHAT COUNTRY? States CE — American Indian, seck, White, etc.
10d. INSIDE CITY LIMITS? 1 YES 2 NO F WHAT COUNTRY? States CE — American Indian, seck, White, etc.
10d. INSIDE CITY LIMITS? 1 YES 2 NO F WHAT COUNTRY? States CE — American Indian, seck, White, etc.
LIMITS? 1 YES 2 NO WHAT COUNTRY? States CE — American Indian, uck, White, etc.
States CE — American Indian, sek, White, etc.
States CE — American Indian, sck, White, etc.
CE — American Indian, ick, White, etc.
ock, White, etc.
MILLCE
and
20817
Town, State
Maryland
hrey Funeral
ntgomery Ave
Approximata interval Between Onset and Death 4 years
4b. WERE AUTOPSY FINDINGS
AMILABLE PRIOR TO COMPLETION OF CAUSE
OF DEATH?
1 TES 2 NO
i Route Number,
e(s) and manner ea stated.
ED (Month, Day, Year)
ber 26, 1994
20895
N l

BALTIMORE, MARYLAND 21215-0020

burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

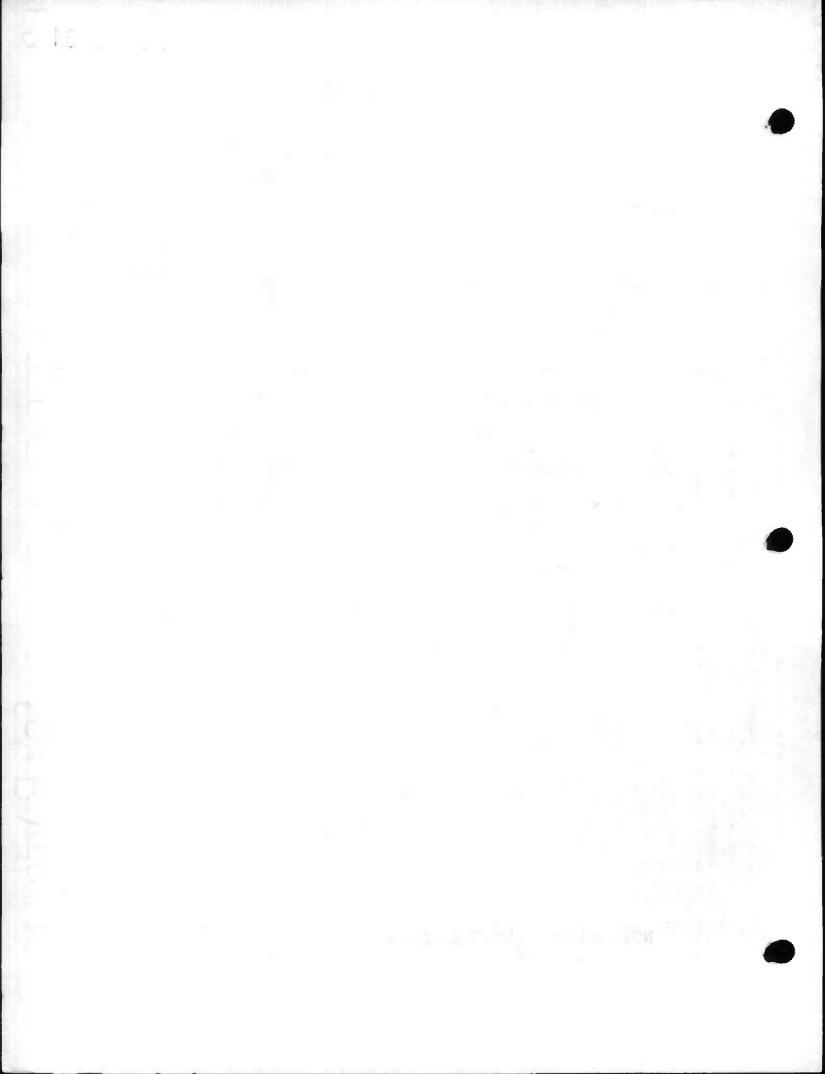
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TEN	TOR:	28
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a flours after death. Page 6 may be retained by the hospital or attending	THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the study within 70 hours after death with the State Date of Health and Mentral Havinge prior to hard command	INPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
PITAL	FRAL	T. H.
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	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN		TMENT OF I		MENTAL HYGIEN		
	1. OECEDENT'S NAME (First, Middle, Last)		OLITINI	OAIL OI	DEATH	2, DATE OF DEATH		3. TIME OF DEATH
- 8	HERVEY GILBERT	MACHEN				November :	AY YEA	AR
			rs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		4 7:40 A M
	215-07-5084	1 ▼ № 2 □ F 78		MONTHS DAYS	HOURS MIN.	Oct. 14,	1916 Was	shington, DC
LOR	9e. FACILITY NAME (If not institution, give atre- 2619 Compass Drive			Annapo	or location of di lis	EATH	Anne A	
ក្ដ	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10c, CITY	Y. TOWN OR LOCA	TION			10d. INSIDE CITY
DIRECTOR		rundel		apolis				LIMITS? 1 YES 2 X NO
M	10s. STREET AND NUMBER			10	f. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
E	2619 Compass Drive				21401		U.S.A	•
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 🔯 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U. FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATE WW TT	NO NO	If yes, s		NIC ORIGIN? (Specify Ye in, Puarto Rican, atc.) y:		RACE — American Indian, Black, White, atc. Specify: White
	15. OECEDENT'S EOUCA			USUAL OCCUPATI	***			
COMPLETED	(Specify only highest grade or Elementary/Secondary (0-12)	ompleted) College (1-4 or 5+)		vork done during m se retired.)			e Pract	
MC	17. FATHER'S NAME (First, Middle, Last)	-	ILCOLIL	7	18. MOTHER'S NA	ME (First, Middle, Maider		100
	Hervey Gilbert Mac	hon Cr				E. Middlet	257000	
8	19a. INFORMANT'S NAME (Type/Print)	itell, or.	T 105 MAIL INC	ADDRESS (Street		Route Number, City or Tox		le l
5	Marian D. Machen	=	The strain like			nnapolis,		
	20a. METHOD OF DISPOSITION 1 Burial 2 □ Cremation 3 □ Remov 4 □ Donation 5 □ Other (Specify)	al from State 20b. P	LACE ANO OATE	or olsposition or other place)	N (Name h Cemeter	OATE 20c. LO	OXOD H	or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICE		-6	22. NAME A	nd address of FA	CILITY n's Sons F	uneral	Home, P.A.
	23. PART i. Enter the diseeses, or co	mplications that caused the	e death Do r					11e, MD 20781
		st only one cause on each		iot enter tha m	ode or dying, auc	m as cardiac or reap	nratory arrest,	Interval Between
	IMMEDIATE CAUSE (Final disease or condition	a para	al He	- 0	76 10		- 6.1.	Onset and Death
	resulting in death) a.	OUE TO (OR AS A CO	ONSEQUENCE OF	ni o	2000	to Carl	77200	110
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate	DUE TO (OR AS A CO	ONSEQUENCE OF	F):	- 2 ale	les ou	holis	
2	CAUSE (Disease or Injury	deffers an	Lungs	cherter	Cardio	valan de	me.	
TIF	that initiated events	DUE TO (OR AS A CO	ONSEQUENCE OF	F):	0	,	-	
ER	resulting in death) CAST	Chronic de	Strul	mo (y a	lowing	disano		
	PART II. Other algnificant conditions	contributing to deeth but	not resulting	in the underlying	ng cause given in		RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE
PHYSICIAN: MEDICAL							2	OF DEATH? 1 YES 2 NO
Ä								
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	LACE OF DEATH (CI	heck only one)		
YSI		1 Inpetient 2 I ER/Outpeti	ent 3 🗆 DOA		me 5 Residence	6 🗆 Other (Specify)		
PH	27. MANNER OF DEATH	(Month, Day, Year)	28b. TIM		JURY AT ORK?	28d. DEŞCRIBE HOW	INJURY OCCUR	ED
ВУ	1 Flatural 5 Pending 2 Accident Investigation			M 1 🗆	YES 2 NO			
	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY — building, etc. (Specify)	At home, farm,	street, factory, offi	ca	28f. LOCATION (Street City or Town, State	t and Number or F e)	Rural Route Number,
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYSIC	AN: To the best of my knowled	ge, death occurr	ed at the time, dat	a and pleca, and du	to the cause(a) and m	enner as stated.	
MC	anal anny	On the basis of examination a						suse(s) and manner as stated.
ö	296. SIGNATURE AND TITLE OF CERTIFIER				1	MARCO	Land outr ou	
BE (Miller	p,			29c. LICENSE NU	MDEK .	29d. OATE SI	GNEO (Month, Day, Year)

Riverdale, Maryland 20737-1394

5711 Sarvis Avenue,
32. Heightrand Signature Fundall

Robert Deitz

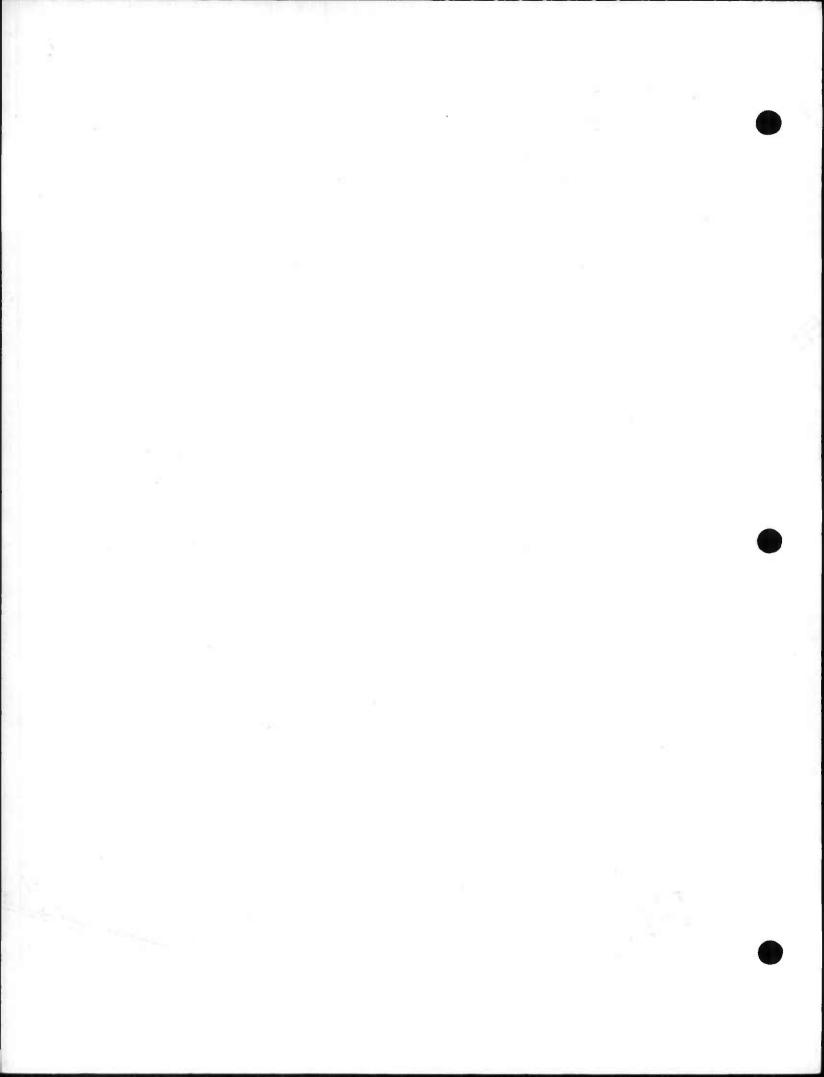


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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
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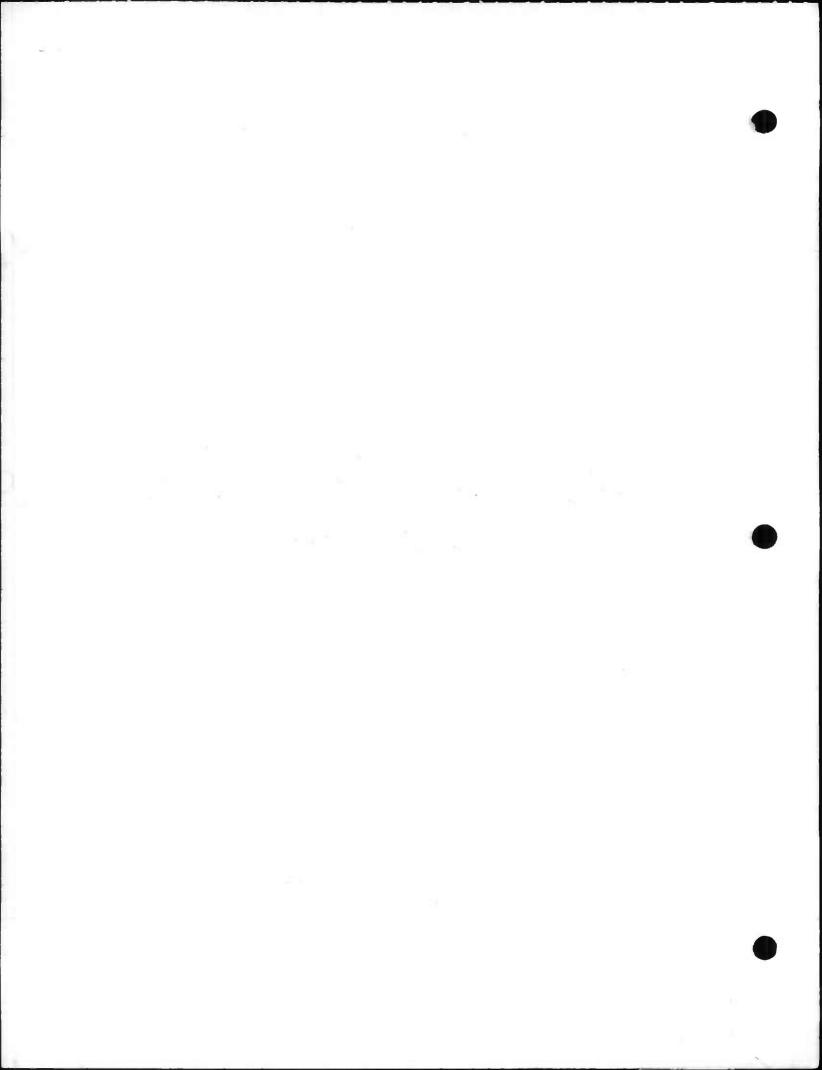
	1 - STATE OF M		MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) Lonzie	0. Mayo M	140	2. DATE OF DEATH MONTH 2904 19	S. TIME OF DEATH A			
	4. SOCIAL SECURITY NUMBER 237-36-1348 5. SEX 1 1 1 1 1 1 F		UNDER 1 YEAR IF UNDER 24 HRS INTHS DAYS HOURS MIN.	(Month, Day, Year)	6. SHRTHPLACE (State or Foreign Country) North Carolina			
TOR	99. FACILITY NAME (If not institution, give street and number) OUTHERN MAY RESIDENCE OF DECEDENT	AND HOSPITAL "	CAN TO A	1	INCK-CEONGS			
DIRECTOR	Maryland PG		ton, Md.		10d. INSIDE CITY LIMITS? 1 X YES 2 NO			
FUNERAL	9211 Stuard Lane		101. ZIP CODE 20735	'	EN OF WHAT COUNTRY?			
В		EVER IN U.S. ARMED YES 2 NO R OR DATES		PANIC ORIGIN? (Specify Yes or No—	14. RACE — American Indian, Black, White, etc. Specify: Black			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Sepondary (0-12) College (1-4 or 5+)	life Do NOT use or	done during most of working httred.)	166. KIND OF BUSINESS/INDU	USTRY			
BE CON	17. FATHER'S NAME (First, Middle, Last) Unknown		18. MOTHER'S Unkn	NAME (First, Middle, Meiden Surneme) OWN				
TO B	19e. INFORMANT'S NAME (Type/Print) Wilma Ross	I		Tal Route Number, City or Town, State, Zip				
	20e. METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify)	20b. PLACE AND DATE OF E	DISPOSITION (Name of	DATE 20c. LOCATION - C	ity or Town, State			
	21. SIGNATURE OF PUNERAL BERVICE LICENSEE	T GIENWOOD O	22. NAME AND ADDRESS OF Plunkett Fur 2504 28th St	neral Home				
	23. PART i. Enter the diseases, or complications that shock, or heart feliure. List only one cause IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (e on aech line.	enter the mode of dying, s	was cerdiec or respiretory arre	Interval Between			
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b							
MEDICAL	PART II. Other significent conditions contributing to decrease the conditions of the conditions contributing to decrease the conditions contributing the conditions conditions contributing the conditions conditions conditions conditions conditions conditions conditions conditions conditions con	when de		In Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
ICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (
BY PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	NJURY 28b. TIME O	F 28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCI	URED			
	3 Suicide 280. PLACE OF	INJURY — At home, ferm, streetc. (Specify)	et, lectory, office	28f. LOCATION (Street and Number of City or Town, State)	or Rural Route Number,			
COMPLETED	29e. CERTIFIER (Check only one) 2 IMEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.							
TO BE C	29b. SIGNATURE AND STITLE OF CERTIFIER	le, m.D.	Page License N	879 m	SIGNED (Month, Day, Year) 20, 1994			
٦	30. NAME AND RODRESS OF PERSON WHO COMPLETED CAUSE ALFONSO VALLE, M.D.	OF DEATH (ITEM 27) (Typo, Pri	RAFTON DIS	E, LARGO, M.	0., 30772			
	31. DATE ENER Month, Day, Your) DECO 1 1994 Lina Do	s signature widson-Randelle						



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	1 - FOR STATE OF MARYLAN REGISTRAR		TMENT OF H		MENTAL HYGIEN	_			
	1. DECEDENT'S NAME (First, Middle, Last)	Makao	10.0		2. DATE OF DEATH MONTH NOVEMBER	%0 10°8	3. TIME OF DEATH		
	Jacques Shederick 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In y)	Morag rs. lest birthdey)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Morth, Pay, Year)	6.8	8:05A M		
	168-03-7905 1⊠ M 2 □ F 87	0,					S.C.		
_	9e. FACILITY NAME (If not institution, give street and number)	R LOCATION OF DE		9c. COUNTY (
TO.	Doctor's Hospital		Lanh	<u>am</u>		PG			
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION								
	Maryland PG 10e. Street and Number	Gi	reenBel				10d. INSIDE CITY LIMITS? 1 🖾 XES 2 🗌 NO		
FUNERAL	6952 Hanover Parkway #100		101	20770		USA	OF WHAT COUNTRY?		
S	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.		13. WAS DEC		IIC ORIGIN? (Specify Ye		RACE — Americen Indian, Black, White, etc.		
В	1 Never Merried 2 Merried FORCES? 1 YES 2 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES		If yes, sp		n, Puerto Rican, atc.)		Black Black		
TEC	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	e. DECEDENT'S (Give kind of v life. Do NOT us	USUAL OCCUPATION	on st of working	16b. KIND OF BU	SINESS/INDUSTR	ny .		
PLE	Elementary/Secondary (0-12) College (1-4 or 5 +)			1	Cha	. 1 M:11	1		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	Ouar	itv Cont		ME (First, Middle, Maiden	Surname)			
BE C	Charles Moragne			Melir	nda Wells	King			
0	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street a	nd Number or Rural I	Route Number, City or Tow	n, State, Zip Code)		
	Jacquelyn D. Moragne 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION /Name of DATE 20c. LOCATION — City or Town, State								
	1 ☐ Buriel 2X_5Cremation 3 ☐ Ramoval from State cemeter	y, cremetory or or			12/1/94 F				
	21 SIGNATURE OF FUNERAL SERVICE LICENSEE	/	22. NAME AN	D ADDRESS OF FA	CILITY				
	Edula Kenner Bor	unli	A -		Young Fur				
	23. PART i. Enter the diseases, or complications that caused the shock, or heart failure. List only one cause on each IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CO	elers	tre e.				Approximate Interval Between Onset and Death		
CERTIFICATION	Sequentially llat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY FINDINGS AMILABLE PRIOR TO								
MEDICAL							COMPLETION OF CAUSE		
M	DID TORACCO USE CONTRIBUTE TO CAUSE OF DEATH. VEG. T. NO. T. LINICEDTAIN TOC								
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN SEED TO								
Sic	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Impetient 2 ER/Outpetier	nt 3 🗆 DOA	OTHER:	s 5 🗆 Residence	6 ☐ Other (Specify)				
F	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. INJ	URY AT RK?	28d. DESCRIBE HOW I	NJURY OCCURE)		
B	2 Accident Investigation			ES 2 NO					
品	3 Suicide 8 Could not be 4 Homicide Catermined 28a. PLACE OF INJURY — At home, tarm, atreet, factory, office 28a. PLACE OF INJURY — At home, tarm, atreet, factory, office City or Town, State) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.								
	296. SIGNATURE AND TITLE OF CERTIFIER		, y openion, u	29c. LICENSE NUN			NED (Month, Day, Year)		
O BE	agraga alle Mis		ĺ	DIA	879	Man	741990		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	(ITEM 27) (Type,	Print) PAF	TON I	DR. LA	1260	140 2077		
	31. DATE FILED (Month, Day, Year) S2. REGISTRAR'S SIGNATURE DFC. 0. 9 1994 Suha Davidse	RE Randa	22		/	-			
	DECO 2 1994 Guha Davidse	7 - 1 - 1							



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Division of virginity, 7.0. Box 68760.	BALLIMORE, MARTLAND ZIZIS-0020
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a frours after death. Page 6 may be retained by the hospital or attending physician.	death, Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	e funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal,	
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	examiner must be notified at once.
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION	TO BE COMPLETED BY FUNERAL DIRECTOR

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last)	MEEKS	 -				MBER 2	້ະ 1ດດ້	3. T	TIME OF DEATH
	MARY 4. social security number 232-96-9938-D	5. SEX 6. AGE (In yrs	s. last birtnday) IF U	NDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE	of BIRTH th, Day, Year)	. 0.		CE (State or Foreign
OR	9a. FACILITY NAME (If not Institution, give st Prince George's Hospit		9b.		R LOCATION OF D			Princ	OF DEATH	ge's
DIRECTOR	100. STATE 10b. COUNTY Maryland Prince	ioc. of the total of				Carrollton 1			I. INSIDE CITY LIMITS? YES 2 NO	
	10e. STREET AND NUMBER			10f	ZIP CODE			10g. CITIZEN	OF WHAT	
FUNERAL	6627 Adrian Street 11. MARITAL STATUS							U.S./	RACE - /	American Indien,
B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2' IF YES, GIVE WAR OR DATES	XXINO	If yes, spe 1 TYES	2 X NO Specific		Rican, etc.)		Black, Wi Specify:	ilfa, afc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementery/Secondary (0-12) / Lh grade	CATION 16a completed) College (1-4 or 5 +)	Give kind of work of life. Do NOT use retir Housewife	one during mo: ed.)	N st of working	164	b. KIND OF BUS Domest		/RY	
BE COM	17. FATHER'S NAME (First, Middle, Last) Johnny Jon	es			18. MOTHER'S NA	AME (First,	Middle, Melden :	Surname)		
TO B	18e. INFORMANT'S NAME (Type/Print) Terresa L. Cone (Great-		6627 Adria	n Street	nd Number or Rural et New Ca	Proute Num	ton, Mar	y land	20784	
	208. METHOD OF DISPOSITION XX Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 200. PLACE AND DATE of Disposition (Name of cally or Town, State cally or To									
	21. SIGNATURE OF FUNERAL SERVICE LIC	ensee Inde	181	Rolli	ns Funera Hunt Plac	1 Hom		ington.	D.C.	20019
CERTIFICATION	23. PART / Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition reaulting in death) Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE DF):									
AL	PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
PHYSICIAN: MEDIC	mall 1 h / 5 / hgs Os structor					OF I	MPLETION OF CAUSE DEATH? YES 2 NO			
IAN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
YSIC	1 VES 2	HOSPITAL: 1 Inpatient 2 ER/Outpatien		HER: Nursing Home	5 - Residence	8 🗆 Oth	er (Specily)			
	27. MANNER OF DEATH Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. fNJI WO 4 1 7	RK?	28d. DE	SCRIBE HOW IN	JURY OCCUR	ED	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined City or Town, State) 289. PLACE OF INJURY — At home, farm, streef, factory, office building, atc. (Specify) 289. PLACE OF INJURY — At home, farm, streef, factory, office City or Town, State)						Number,			
COMPLETED		CIAN: To the best of my knowledge							euse(a) and	i menner ea stated.
TO BE CO	294-STONATURE AND TITLE OF CERTIFIER	reho			29c. LICENSE NU		2_	29d. DATE SI	GNED (Mor	nth, Day, Year)
5	30. NAME AND ADDRESS OF PERSON WHO PAUL DEVORE, M.D.	•			QUEENSE					
	31. DATE FILE THOM OF YES	32. REGISTHAR SIGNATUR	in-Handell		,		,			

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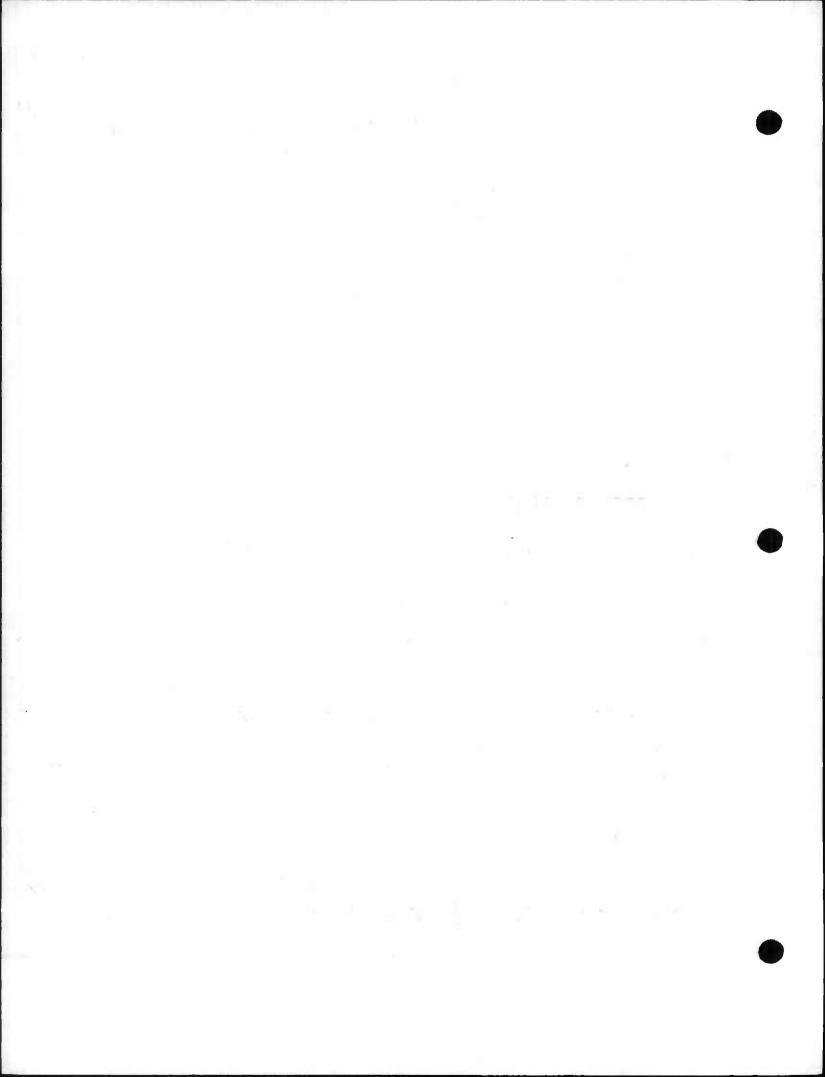
HYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
SICIAN: The law requires that the death ce	certificate has been signed by the attendir the State Dept. of Health and Mental Hy	1, or item 23 shows any injury, or o
THE HOSPITAL OR ATTENDING PHYSI	THE FUNERAL DIRECTOR: After this is filed within 72 hours after death with	IMPORTANT: if item 28 is marked

1994

	1 - STATE REGISTRAR SIAIE OF MARYLAND / DEPARTMENT OF HEALTH								
	1. OECEOENT'S NAME (First, Middle, Last) EVA MASON	2. DATE OF DEATH	3. TIME OF DEATH 4:52p.m. M						
	579-58-7621 1 □ M 2 🗶 F 92 YRS. MONTHS DAYS HOURS	7. DATE OF BIRTH MIN. FEB. 2, 1902	8. BIRTHPLACE (State or Foreign VIRGINIA						
TOR	90. FACILITY NAME (If not Institution, give street and number) DOCTORS COMMUNITY HSOPITAL 90. CITY, TOWN OR LOCATION OF DEATH LANHAM→SEABROUK 90. COUNTY OF DEATH PRINCE GEORGE'S								
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MARYLAND PRINCE GEORGES 10c. CITY, TOWN OR LOCATION HYATTSVILLE 10d. INSIDE CIT LIMITS? 1 X YES 2								
FUNERAL	100. STREET AND NUMBER HYATTSVILLE MANOR 20789		EN OF WHAT COUNTRY? TED STATES						
BY FUN	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT	an, Maxican, Puarto Rican, etc.)	14. RACE — American Indian, Black, Whita, atc. Specify: BLACK						
PLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) The control of the contro		USTRY						
E COMPL	AUADIES DESC	THER'S NAME (First, Middle, Meiden Surname) ARY BRICE							
TO B	196. INFORMANT'S NAME (Type/Print) BERTHA JACKSON 19b. MAILING ADDRESS (Street and Number 4205 19TH PL. N.	or or Rural Route Number, City or Town, State, Zip. E., WASHINGTON,							
	209. METHOO OF DISPOSITION 1X Burial 2 Cremation 3 Temoval from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Cempletry, Crematory or other place) GLENWOOD CEMETERY	DATE 20c LOCATION - C	City or Town. State						
	2. M. A. DOUDLEY UNERAL HOME 3200 RHODE ISLAND AVE., MT. RAINIER, M								
CERTIFICATION	23. PART I. Enter the diseases, or complicatione thet ceused the death. Do not enter the mode of dy shock, or heart feliure. List only one cause on each death. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Sequentially list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST		Approximate interval Between Onset and Death 5:35 @~						
MEDICAL CE	PART II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24e. WAS AN AUTOPSY PRIDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?								
PHYSICIAN: M	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
YSIC	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Re	ssidence 8 - Other (Specify)							
ВУ РН	2 Accident	28d. DESCRIBE HOW INJURY OCC	URED						
	3 Suicide 8 Could not be 4 Homicide 8 Could not be detarmined 28s. PLACE OF INJURY — At home, tarm, afreet, factory, offica building, atc. (Specify) 28s. PLACE OF INJURY — At home, tarm, afreet, factory, offica City or Town, State)								
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and place of my knowledge, death occurred at the time, data and the my knowledge of my knowledge.								
BE (29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICI	ENSE NUMBER 29d. DATE	SIGNED (Month, Day, Year)						
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)	46093	128/94						
)	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) RAMMAN MOSTAGEMEN 7305 HANDY AFTER 31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNATURE NOV 2. 9 1994 Julia Davidson-Randelle	y, Grunbelt mo	20770						
	NOV 2 9 1994 Julia Davidson-Randell								

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BALTIMORE, MARYLAND 21215-0020	* hours after death. Page 6 may be retained by the hospital or attending physician.	s been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should pt. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Extroours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Leet)		MOO	RE		2. DATE OF DEATH	3.19	3. TIME OF DEATH P
		5. SEX 6. AGE (III		UNDER t YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug 26,19		s. BIRTHPLACE (State or Foreign Country) Wash., D.C.
	9a. FACILITY NAME (If not institution, give stre		96	o. CITY, TOWN C	R LOCATION OF D			TY OF DEATH
DIRECTOR	SOUTHERN MARYLAND	D HOSPITAL CLINTON			N		NCE GEORGES	
JIRE(NA NA		7	OWN OR LOCAT INGTON,				10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER		WASII		ZIP CODE		10g. CITIZ	1 X YES 2 □ NO EN OF WHAT COUNTRY?
ER/	2839 Robinson Plac	e, S.E. #403	3		20020		1 -	ED STATES
BY FUNERAL		12. WAS OCCEDENT EVER IN FORCES? 1 YES	U.S. ARMED 2 X NO	If yes, spi	ENDENT OF HISPAI celfy Cuban, Mexica 2 X NO Specifi	NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.)		14. RACE — American Indian, Black, Whita, etc. Specify: BLACK
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	(TION ompleted)	16a. DECEDENT'S USI	UAL OCCUPATIO	N st of working	16b. KIND OF BU	ISINESS/INDU	
,E	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use re	Nired.)		HOGDIM	A T	
N N	17. FATHER'S NAME (First, Middle, Last)		CLERK		18 MOTHED'S NA	HOSPIT		
	FRANK OLIVER					RED MOORE	i Sumame)	
) BE	19a. INFORMANT'S NAME (Type/Print)	············	19b. MAILING AD	DRESS (Street a		Route Number, City or Toy	vn, State, Zip (Code)
5		(MOTHER)				le Hills,		
	20e_METHOD OF DISPOSITION 1		PLACE AND DATE OF D tery, cremetory or other EDAR HILL					or Town, State MARYLAND
	21. SIGNATURE OF FUNERAL SERVICE LICE			22. NAME AN	D ADDRESS OF FA	CILITY		
	· aller & Fin	h	M859	2617	Pennsy1	POPE FUNI Lvania Ave	nue. S	SE DC 20020
	23. PART I. Enter the disasses, or co shock, or heart fallure. Li	mplications that caused ist only one cause on as	tha daath. Do not	antar tha mo	da of dying, suc	h as cardiac of reap	iratory arre	st, Approximate
	IMMEDIATE CAUSE (Final disease or condition			1 ,	tomo			Onset and Death
ľ	disease or condition resulting in death) a. Chrock of the stornach Due to (or as a consequence or)							
N	Sequantially list conditions, Due to (or as a consequence or):							
ATI	if sny, laading to immediata cause. Entar UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION	CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):					
CER	d.							
AL.	PART II. Other algnificant conditions	contributing to death bu	t not reaulting in t	ha undariying	cause givan in	Part I. 24a. WAS AN		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
EDIC						1 - YES	2 NO	COMPLETION DF CAUSE OF DEATH?
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO NO							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				ACE OF DEATH (Ch			
SIC		HOSPITAL: 1 Inpetient 2 ER/Outpe		THER: Nursing Home	5 Rasidence	8 Other (Specify)		
PH	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME O		JRY AT RK?	28d. DESCRIBE HOW	INJURY OCCU	JRED
ВУ	2 Accident Investigation	AR- BI AGE OF IN HIM			ES 2 NO			
TED	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY - building, atc. (Specif	— At home, farm, atree (y)	et, factory, office		28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
COMPLET		AN: To the best of my knowle						d. cause(a) and manner as stated.
ECC	29b. SIGNATURE AND TITLE OF CERTIFIER				29c LICENSE NUI			SIGNED (Month, Day, Year)
TO B	aufmin	alle h	1.D		012	879	12	10.25,1994
F	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA	TH (ITEM 27) (Type, Pri	TEN.	FON	DR! LA	RGO	10 20772
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA			-			
								- 1



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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	1 - FOR STATE REGISTRAR	STATE OF MARYLAN		MENT OF H		MENTA	L HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH		3. TIME OF DEATH
		Elizabeth Ju	lia Mar	ra		NOV	21.19		10:30 PM
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yr.	s. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mont)	OF BIRTH	a	BIRTHPLACE (State or Foreign Country)
	578-48-5801		57 YRS.				h 25,1		enn.
E.	90. FACILITY NAME (If not institution, give sta 9800 Rosaryville		ĺ		Marlboro				of DEATH Ce George's
5	RESIDENCE OF DECEDENT								
DIRECTOR	10e. STATE 10b. COUNTY			TOWN OR LOCAT					10d. INSIDE CITY LIMITS?
	Maryland Prince	ce George's	Upr	er Marl	DOTO ZIP CODE			L OFFITE	1 TYES 2 NO
FUNERAL	9800 Rosaryville	Road			20772				N OF WHAT COUNTRY?
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S	S. ARMED	13. WAS DEC	ENDENT OF HISPAN	IC ORIGIN	17 (Specify Yee		ed States RACE — American Indian,
ВУ Б	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES		If yes, spe	city Cuban, Mexicer 2 NO Specify		Ricen, etc.)		Black, White, etc. Specify:
	15. DECEDENT'S EDUC	ATION 184	DECEDENT'S I	ISUAL OCCUPATIO	· Al	1445	. KIND OF BUS		White
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4 or 5+)		ork done during mos		100	. KIND OF BUS	SINESS/INDUS	THY
MP		2	Homema	ker			Own H	ome	
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM		Middla, Meiden	Surname)	
BE	Alfonso Procopio				Rose M				
욘	190. INFORMANT'S NAME (Type/Print) Julio Marra				nd Number or Rural R				o, Maryland
	20a. METHOD OF DISPOSITION	20h PI (<u> </u>	F DISPOSITION (Nat		DAT	~		y or Town, State
	1 XBuriel 2 Cremetion 3 Remo								am, Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE		22. NAME AN	D ADDRESS OF FAC	T YILIK	ee Fur	eral I	Home, Inc 6633
	Charles o	T. Belong	el	old Al	exander :				nton, MD 20735
	23. PART I. Enter the diseases, or conshock, or heart failure. L	omplications that ceused the	e deeth. Do no	ot enter the mod	de of dying, such	as cere	lac or respi	ratory arres	t, Approximete
	IMMEDIATE CAUSE (Finel disease or condition			0	MASCU	11.	11.		
	resulting in deeth)	DUE TO (OR AS A CO)			AN AN COL	1-1:1:10	dis	ease	- HUM
z	<u>.</u>		NOLOOLINGE OF						í
E	Sequentially list conditions, if any, leeding to immediate	DUE TO (OR AS A CO	NSEOUENCE OF)	:					
<u>5</u>	CAUSE (Disease or Injury	PHE TO (OR 40 A CO)	NOTOLIENOS OF						
CERTIFICATION	thet initieted events resulting in death) LAST	DUE TO (OR AS A COM	NSECUENCE OF)	4					
		•							
SAL	PART II. Other significant conditions	contributing to death but n	not resulting in	the underlying	ceuse given in i	Part I.	24e. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
MEDIC						-	t TYES 2	₹ NO	OF DEATH?
Σ	DID TOBACCO USE CONTR	IRLITE TO CALISE OF P	EATH VE		LINICEDTAIN				1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26. F		(Check only one)	UNCEKIAIN	1			L
SIC	EXAMINER?	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatien		OTHER:	5 XRaeldence	6 🗆 Othe	r (Specify)		
F	27. MANNER OF DEATH	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU	OF 26c. INJU		28d. DES	CRIBE HOW II	NJURY OCCUP	RED
B	1 Natural 5 Pending 2 Accident Investigation				ES 2 NO				
9	3 Suicide 6 Could not be 4 Homicide determined	26a. PLACE OF INJURY A building, atc. (Specify)	At home, ferm, st	reet, factory, office		26f. LOC.	ATION (Street a or Town, State)	nd Number or	Rural Route Number,
	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner as stated. 2 XMEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner as								
N C	one)	Con the basic of examination end							
	296. SIGNATURE AND TITLE OF CHRYSPER	0.	205 KT		A LICENSE NUM				IGNED (Month, Day, Year)
) BE	Trunsto Y. X	tdugget is	M		1212	30		Men	When 72/9/1
2	SO, HAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH	(ITEM 27) / Type: /	90 1	1.111	7	1	241	1 - 01
)	MUSEUS P. KOCH	guageme,	5007)	CoyDer	MUTCH	PS	Spo	1110	20748
	NOV 2 9 1999	Julia Davidos	m-Mande	22		,	/		

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DIVISION OF VITAL RECORDS, P.O. BOA 88/50,	ATTEN	CTOR
5	L OR	L DIR
	E HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within mounts after death. Page	E FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral of
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31. DATE FILD POT ON 91994

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

27 Trail A

Julio Menocal, M.D.,

MORE, MARYLAND'21/215-002 ge 6 may be retained by the hospital irrector, page 5 should be detacted TO THE HOSPITAL OR ATTENDING PHYSICIAN. THE NEW YORK TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely hines in by the source. To there this certificate has been signed by the attending physician and completely hines in by the source. To the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, crematic event, the medical examiner must be notified at once. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYL			OF HEALTH ANI		GIEN	_	•	
	1. DECEDENT'S NAME (First, Middle, Last)	Catherine			MAY	2. DATE OF DE	EATN DA	AY	YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 213-74-3948	5. SEX 6. AGE (. D. (In yrs. lest birthday) YRS.	IF UNDER 1	YEAR IF UNDER 24 HRS DAYS HOURS MIN	FEB 2	DTH		0. BIRTI	HPLACE (State or Foreign
TOR	99. FACILITY NAME (If not institution, give s 4103 Araby Chi RESIDENCE OF DECEDENT				rown or Location of Frederick	DEATN		100	rede:	rick
DIRECTOR	MD. Tree in the country in the count	•	10c. CIT	TY, TOWN OF	DERICK					10d. INSIDE CITY LIMITS? 1 YES 2 NO
VERAL	100. STREET AND NUMBER 4103 ARABY CHURCH	ROAD			101. ZIP CODE 2:	1701				WHAT COUNTRY?) STATES
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced									
COMPLETER	15. DECEDENT'S EDU (Specify only highest grade Elemenitary/Secondary (0-12)	CATION completed) Caffinge (1-4 or 5+)	16a. DECEDENT'S (Give kind of life. Do NOT un HOMEMAK	work done du se retired.)	CUPATION tring most of working		OF BUS	HOM		
BE CO		DAY			DRUCS	NAME (First, Middle, SCILLA		(U	NKNO	own)
2	190. INFORMANT'S NAME (Type/Print) FRANCIS MAY		196. MAILING 4103		Street and Number or Ru SY CHURCH 1					21701
	20e METNOO OF DISPOSITION 176 Buriel 2 Cremetion 3 Rem 4 Donetion 5 Other (Specify)	oval from State 20b	AYTONSVI	of disposit	ION (Name of EMETERY	0ATE 12/8		cation — TONS		own, State LE, MD.
	21. SIGNATURE OF FUNERAL SERVICE LIC	4-Bark	w	P.	AME AND ADDRESS OF RIEL H. B. O. BOX 50	38 LAYTO	ONSV	/ILLE	, MI	
		complications that caused List only one cause on a	d tha death. Do i ach lina.	not antar ti	ha moda of dying, s	uch as cardiac p	r reapl	ratory ar	rest,	Approximats Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in dasth)	- Cerebrou	CONSEQUENCE O	A	udent	4				Swys.
ATION	Sequentisity list conditions, if sny, leading to immediate cause. Enter UNDERLYING	- Asev								12411
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE O	F):						
- 1	PART II. Other algorificant condition	a contributing to death b	ut not resulting	In the und	erlying cause given		WAS AN	AUTOPSY	248	b. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICAL	Seuve C	NTEUANTITY NTENSION	NTII				YES 2		-	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
N.	DID TOBACCO USE CONTI			S N	O 🗷 UNCERTA	AIN 🗆				1 YES 2 NO
ICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEA	TN (Check on						
HYS	1 TYES 2 TO NO 27. MANNER OF DEATN	1 Inpatient 2 ER/Outp	patient 3 DOA 26b. TIM		ng Nome 5 Amesident	28d, DESCRIBE		N HIBY OC	CHRED	
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	IN.	M	WORK? 1 YES 2 NO	Zau. DEJONIO	. 11011	NJOHT OC	CONED	
B	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	— At home, term,	street, fector	y, office	281. LOCATION City or Tow		and Number	or Rural	Route Number,
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of my snow			e, date end place, end o					e) and menner se stated.
BE	29b. SIGNATURE AND TITLE OF CERTIFIER)		29c. LICENSE I					(Month, Day, Year)
임	20 NAME AND ADORSES OF DEDOON WILL	INO COMPLETED CAUSE OF OFATA (ITEM 27 CERT CAUSE)								

516 Trail Avenue, Frederick, Md. 21701

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Vermont

10g. CITIZEN OF WNAT COUNTRY?

Specify

Montgomery Co

9c. COUNTY OF DEATH

USA

20c. LOCATION — City or Town, State

2. DATE OF DEATH 11 - 25 - 94 MONTH 25 94

16b. KIND OF BUSINESS/INDUSTRY

Education

24a. WAS AN AUTOPSY PERFORMED?

1 TYES 2 NO

28d. DESCRIBE HOW INJURY OCCURED

D27301

w. Montoner

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

8/20/01

7. DATE OF BIRTH

OATE

in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should removal. the hospital or attending physician. 3 Page 6 may be retained 6 filled completely filled rial, cremation, been signed by the attending physician and con it, of Health and Mental Hygiene prior to burial, requires that the death certificate be has be Dept. ₩. OR ATTENDING PHYSICIAN: The certificate his this c After 1 THE FUNERAL OIRECTOR: After the filed within 72 hours after dea MPORTANT: If Item 28 is m TO THE HOSPITAL OR ATTI TO THE FUNERAL OIRECTO be filed within 72 hours att

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Dars-495

31. DATE FILEO (Month, Day, Year)

FOR STATE REGISTRAR

1 -

1. DECEDENT'S NAME (First, Middle, Last) Marguerite McKenzie Ya 8. AGE (In VIS 4. SOCIAL SECURITY F UNDER 1 YEAR | IF UNDER 24 HRS. 30 1 M 2 F DAYS HOURS YRS. 9b. CITY, TOWN OR LOCATION OF DEATH FUNERAL DIRECTOR advent18 Shady GINNE OF DECEDENT Rockville 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Co Rockville Montgomery 10e. STREET AND NUMBER 10f. ZIP CODE 9701 Medical Center Drive 20850 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxican, Puerto Rican, atc.) BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY 1 YES 2 NO Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 12+ Teacher notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Patrick Henry McDonough BE Edith Mc Donough 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Louise O'Brien 15005 Flower Valley Ct, Rockville, MD 20853 e 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of must 20s. METHOD OF DISPOSITION

1 Burlal 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEER on ald Wade, Dir examiner 22. NAME AND ADDRESS OF FACILITY State Anatomy Board 655W.BaltimoreSt,Balto,MD21201 medicai 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardisc or respiratory errest, shock, or haart failure. List only one cause on each line. **IMMEDIATE CAUSE (Final** the diseese or condition resulting in death) Mackerl traumatic event, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentisity list conditions, BOX if sny, leading to immediate cause. Enter UNDERLYING O STROGOTOCO other CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events 0 resulting in death) LAST 6 injury, RECORDS, PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL shows any 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Hem HOSPITAL: OTHER:
Nursing Home 5 - Residence 8 - Other (Specify) 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 0 27. MANNER OF OEATH PP 28a. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT marked, Netural
Accident
Suicide 5 Pending DIVISION ВY 1 YES 2 NO Investigation 28s. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify) 8 Could not be 4 Homicide COMPLET 29a, CERTIFIER SERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE

Comors

- HUMAKER MO

32. REGISTRAR'S SIGNATURE

60

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Ellen

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

White

Approximate

24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO

> OF DEATH? 1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

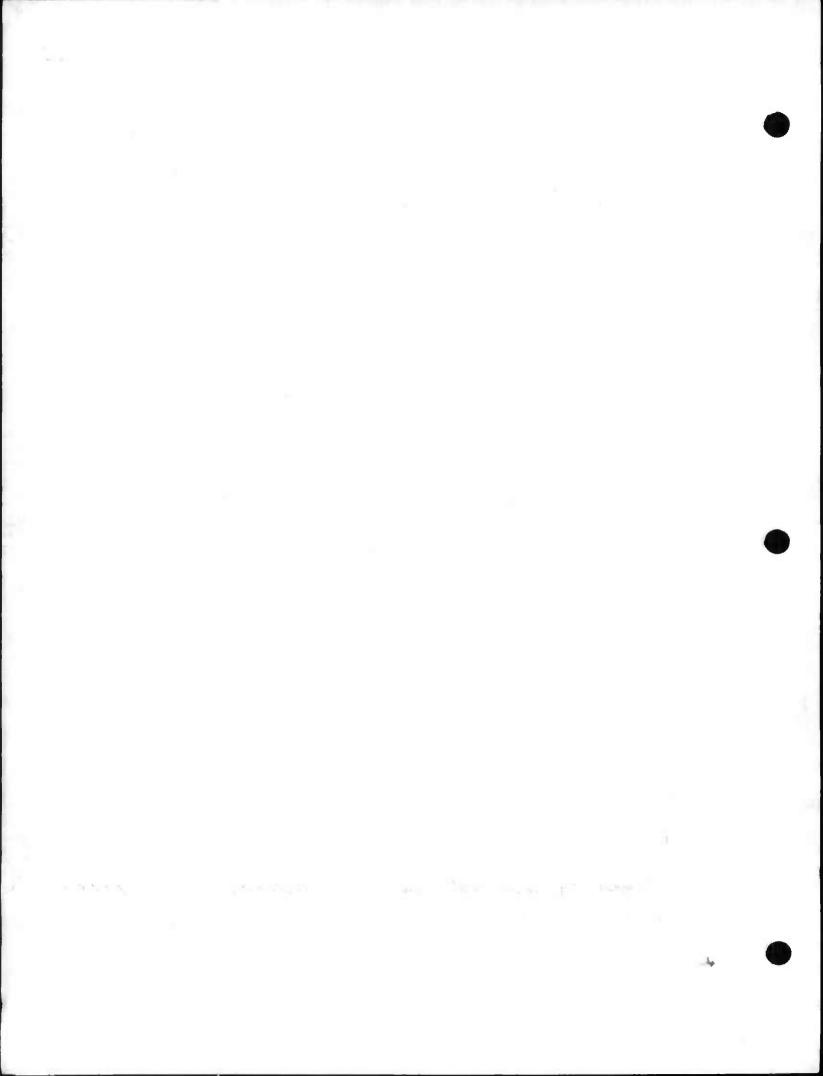
11/2579

COMPLETION OF CAUSE

Intervsi Between

Onset and Death

1 YES 2 NO



Pages 1, 2, 3 should

permit.

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BE 2 3 Suicide

4 Homicide

LEU

5 Could not be

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 hours after do THE FUNERAL ORECTOR: After this certificate has been signed by the attending physician and completely filled in the be filled within 72 hours after death with the State Dept. of Health and Mental Hyghene prior to burial, certainion, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical e	DALIMONE,	r death. Page 6 may be	he funeral director, page al.	examiner must be r
		TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 6 may be	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page to filled within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be r

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH RICHARD WARREN MYERS, SR. 8:30 PM 11 74 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year)
Dec 13, 8. BIRTHPLACE (State or Foreign 5. SEX IF UNDER 1 YEAR | IF UNDER 24 HRS DAYS HOURS 1937 MARYLAND 1 MAIDE 217-34-1254 56 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Sc. COUNTY OF DEATH DIRECTOR FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK RESIDENCE OF DECEDENT FREDERICK 10d. INSIDE CITY
LIMITS?
1 YES 2 NO FREDERICK FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 10114 OLD LIBERTY RD. U.S.A. 21701 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 (IF YES, GIVE WAR OR DATES YES 1 Never Married 2 Married Specify: 1 TES 2 NO BY 3 Widowed Mar Phoreed WHITE COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 166. KIND OF BUSINESS/INOUSTRY (Specify only highest grade compa Elementary/Secondary (0-12) College (1-4 or 5+) 12 MAINTENANCE SUPERVISOR POSTAL SERVICE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ALLYN H. MYERS VADA G. EYLER BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 FRANCES A. MYERS 10114 OLD LIBERTY RDFREDERICK MD 21701 20a. METHOD OF DISPOSITION BURTAL
1 Burial 2 Gremation 3 Hamoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State WELLER CEMETERY 12/1 4 Donation 5 Other (Specify). THURMONT, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY D. D. HARTZLER & SONS atharine WOODSBORO, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on aech line. Interval Between IMMEDIATE CAUSE (Final Onset and Death Myochalal disesse or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II Other significant conditions contributing to death but not resulting in the undarlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY PERFORMED? MEDICAL ulosos 1 TYES 2 NO OF DEATH? 1 TES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER: 1 TES 2 NO 1 Inpetient 2 - ER/Outpatient 3 - DOA ng Home 5 - Rasidence 6 - Other (Specify) 27. MANNER OF GEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED Natural м 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

29e. CERTIFIER
(Check only one)

2 | CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

		(-)
HE AND TITLE OF CENTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

Commence of the contract of th		
296. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, L
Alle - 11/62	D26566	11/30

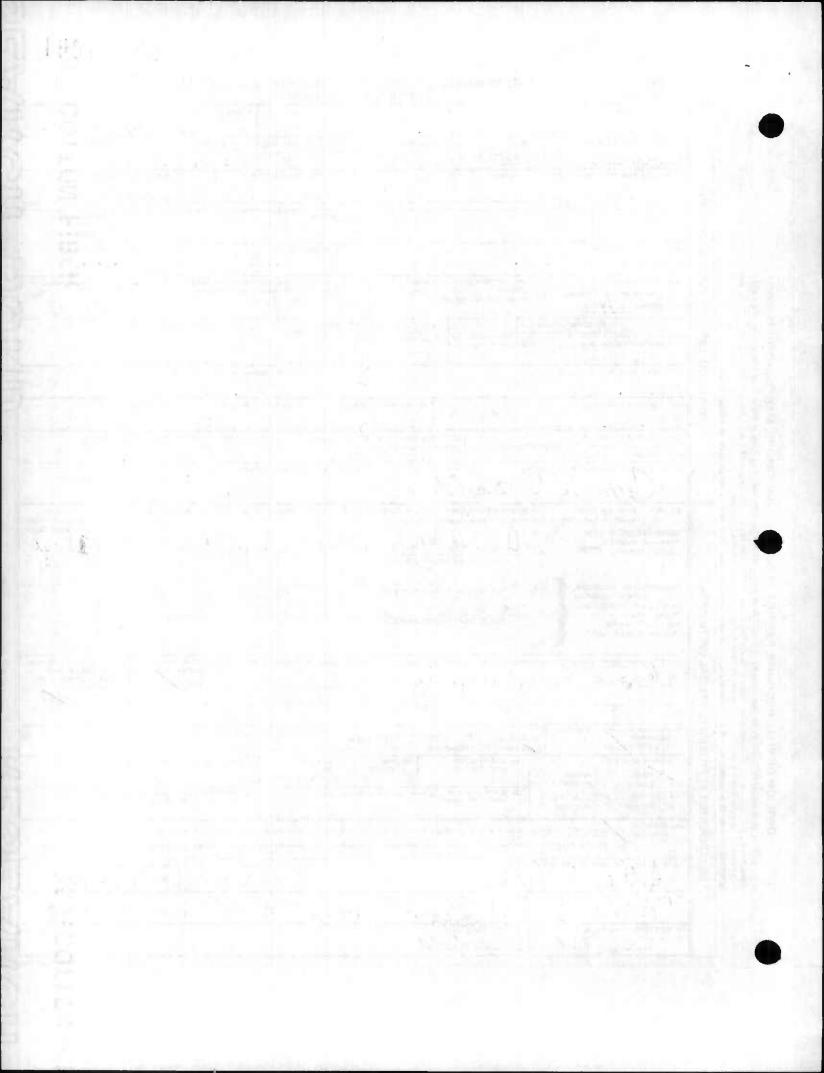
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MAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		1		

62: SORLING 14755 31. DATE FILED (Month), Day bery

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281. LOCATION (Street and Number or Rural Route Number, City or Town, State)



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S	E	品	28
DIVISION OF VITAL RECORDS, P.O. BOX 13146,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 🛫 wours after death. Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	표	THE Bed	POR
	2	23	X

	1 - STATE REGISTRAR Gladys M. McDowell		ICATE OF	DEATH		G. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DE	EATH	,	EAR 3. TI	ME OF DEATH			
	Gladys I. Mc Oowell								6 am M			
3	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs.		MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BII (Month, Day,	RTH Year)	6.	BIRTHPLAC Country)	E (State or Foreign			
	236-20-9664 10 M2 XF 89	YRS.			11 - 3	26-0	74 M	incra	1 Co. WV			
œ	9e. FACILITY NAME (if not institution, give street end number)		96. CITY, TOWN O	OR LOCATION OF DE	EATH	5	c. COUNT	OF DEATH				
10	Moran Manor		Wester	port			Alle	cany				
EC	10s. STATE 10b. COUNTY	10c. CIT	Y, TOWN OR LOCAT	ION				10d.	INSIDE CITY			
DIRECTOR	WV Mineral		Keyser						LIMITS? YES 2 NO			
	10e. STREET AND NUMBER		_	. ZIP CODE		1	log. CITIZE	N OF WHAT	COUNTRY?			
ER/	50 James Street			26726			Min	eral				
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S.			ENDENT OF HISPAN			No- 14	. RACE — A	merican Indian,			
ВУ Е	1 Never Merried 2 Merried FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	Хио		cify Cuben, Mexice 2 XNO Specif		etc.)		O	White			
ED B									MITCE			
TE	(Specify only highest grade completed)		WORL OCCUPATE work done during mo se retired.)		166. KJND	OF BUSIN	ESS/INDUS	TRY				
PLE	Elementary/Secondary (0-12) College (1-4 or 5+)	eachei			E	ducat	ion					
COMPLET	17. FATNER'S NAME (First, Middle, Last)	caciici		18. MOTNER'S NA	_							
	George Richards			Bertie	e Kimme	11						
BE (19b. MAILING	ADORESS (Street	nd Number or Rural			State, Zip Co	ode)				
5	William R. McDowell	82 Se	econd St	reet, Pie	edmont,	WV.	267	50				
	20e. METNOD OF DISPOSITION 1 V Burdel 2 Commellon 2 Bernoval from State	E OF DISPO	SITION (Name of cer	netery, crematory or		20c. LOCA	TION — CI	y or Town, S	tate			
	1 M Burisi 2 Cremation 3 Removal from State other piece) 4 Donellon 5 Other (Specify) Queens POINT Cemetery 11/24/94 Keyser, WV.											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	Hard Dean not sing	4							26726			
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate											
	ahock, or heart fallure. List only one cause on each line. Interval Between Onset and Death											
	disease or condition as. Due to (or as a cons	Nonz	- dy	5/9 H	n-2-			İ				
	DUE TO (OR AS A CONS	SEOUENCE C	PF):	-	CAP.							
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CERTIFICATION	Sequentially list conditions, if any, leading to immediate											
2	CAUSE (Disease or injury CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF):											
Ē	thet initiated events out to (or as a consequence of): resulting in deeth) LAST											
CEI	d											
	PART II. Other significant conditions contributing to death but no	t resulting	in the underlyin	g ceuse given in		WAS AN AL			E AUTOPSY FINDINGS ABLE PRIOR TO			
DICAL					10	1 TYES 2 TO NO COMPLETION OF CAUSE OF DEATH?						
ME					_			1 🗆	YES 2 NO			
PHYSICIAN: ME												
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		28. P	LACE OF DEATH (C)	neck only one)							
YSI	1 TES 2XXNO 1 Inpatient 2 ER/Outpatient		4 Nursing Hon	ne 5 🗆 Residence								
	27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Dey, Year)	26b. Till IN	JURY WO	DRK?	28d. DESCRIB	E NOW INJ	URY OCCU	RED				
ВУ	Z Accident Investigation	home form		YES 2 NO	28f. LOCATION	I (Steed on	d Mumber o	Dural Bouds	Mumbae			
COMPLETED	3 Suicide 6 Could not be detarmined 286. PLACE OF INJUNY — At building, etc. (Specify)	Troning, racing	attest, factory, office		City or Tow	n, State)	a trovinous or	norm noore	varrioui,			
LET	29a. CERTIFIER											
MP	(Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, one) 2 MEDICAL EXAMINER: On the basic of examination end/											
00		or investigate	on, in my opinion, s									
BE	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU		1	29d. DATE S	SIGNED (Mon				
10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (I	TEM 27) (5	e Print)	17712	44		_	11/27	454			
	Dr. Jesus H. Tan, MD Frostburg P			ra. Maru	1and 21	532						
	31. DATE FILED (MONTH AND 1997) 32. REGISTRATUS SIGNATURE	0 1 00	1100000	-9, nary	Turiu 4.							
	31. DATE FILED (MONTO DON 1978 1994 32. HEGISTRAN'S SIGNATURI	narda										

4. SOCIAL SECURITY NUMBER 292-20-5515 le law requires that the death certificate be executed with thours after death. Page 6 may be retained by the hospital or attending physician.

The bean signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be the permit and Merrial Hygiene prior to burial, cremation, or removal. 9e. FACILITY NAME (If not institution, give DIRECTOR Moran Manor N RESIDENCE OF DECEDENT 10e. STATE 10b. COUN Md Al BE COMPLETED BY FUNERAL 10e. STREET AND NUMBER 105 Wood St. 11. MARITAL STATUS BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried 3 🕅 Widowed 4 🗌 Divorced 15. DECEDENT'S EC (Specify only highest grad Elementary/Secondary (0-12) Unknown once. 17. FATHER'S NAME (First, Middle, Last) notified at Samuel Wiland 19e. INFORMANT'S NAME (Type/Print) 2 Adele Taylor pe 20s. METHOD OF DISPOSITION
1X Burlel 2 Cremetion 3 Re must Donetion 6 - Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE examiner medical 23. PART I. Enter the diseases, or ahock, or heart failure IMMEDIATE CAUSE (Finel the disease or condition_ resulting in death) other traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760 CERTIFICATION Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disease or injury OUE TO (OR AS A CONSEQUENCE OF): that initiated evente resulting in death) LAST 6 23 shows any Injury, PART ii. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 25. WAS CASE RI EXAMINER? 1 YES 2 DIRECTOR: After this certificate I hours after death with the State marked, or 27. MANNER OF Netural 2 Accident BY Suicide 69 COMPLETED 8 28 4 Homicide

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TO THE HOSPITAL OF THE FUNERAL D DE filed within 72 h

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FOR STATE REGISTRAR		STATE OF N	MARYL				NT OF H			MENT/	AL HYGIEN				
1. DECEDENT'S NAME (First	, Middle, Last)									2. DAT	E OF DEATH			3. TIME OF DEATH	
FLORENCE	W. N	IARTIN								NC	₩. 23	199	4 YEAR	6:30p) м
4. SOCIAL SECURITY NUMBER	BER	5. SEX	8. AGE	In yrs. lest	birthday)		DER 1 YEAR	IF UNDER			OF BIRTH		8. BIRTH	IPLACE (State or For	niger -
292-20-5	515	1 🗆 M 2 💢 F		97	YRS.	MONTH	B DAYS	HOURS	MIN.		th, Day, Year) . 14 1	.896	Countr	Md	
90. FACILITY NAME (If not in	nstitution, give s	street and number)				9b. C	ITY, TOWN C	R LOCATI	ON OF DE	EATH		9c. COL	JNTY OF D	DEATH	
		ursing Ho	ome				West	ernpo	ort			Al	legar	ny	
RESIDENCE OF DEC	10b. COUNT				40- 017	w 7000	N OR LOCAT	100							
Md		legany					ternp							10d. INSIDE CITY LIMITS? 1 X YES 2 1	10
10e. STREET AND NUMBER		2 - 6 - 2 - 2						ZIP COD	F.			10a. Cl	IZEN OF V	WHAT COUNTRY?	
105 Wood St.								2156	70			II			
11. MARITAL STATUS Never Married 2 Merried Merrie				2 VN	VINO If yes, specify Cuban, Maxican, Puerto Rican, atc.) Bis					Black	E — Americen Indien, k, White, atc. White				
15. DEC (Specify onl	EDENT'S EOU	CATION completed)		(Gi	ve kind of v	vork do	OCCUPATIO		ng	16	b. KIND OF BI	USINESS/IN	DUSTRY		
Elementary/Secondary (0-12)	College (1-4 or 5	+)	Me.	Do NOT us	e retire	d.)								
Unknown				Ho	mema	ker	<u> </u>				Home	j			
17. FATHER'S NAME (First, M	fiddle, Last)							18. MOT	HER'S NA	AME (First	Middle, Maide	n Sumsme)			
Samuel Wi	land							Не	nri	etta	Broad	lwate:	r		
19e. INFORMANT'S NAME (Type/Print)			19b	. MAILING	ADDR	ESS (Street e	nd Number	r or Rural	Route Nu	mber, City or To	wn, State, Z	ip Code)		
Adele Ta				39	055	Gar	densi	de D	r.,	Wil	loughb	y,0h	io 4	4904	
209. METHOD OF DISPOSIT	ION	and form State	20t	. PLACE A	ND DATE	OF DISF	POSITION (Ne	me of		OA	TE 20c. L	OCATION -	- City or To	own, State	
4 Donetion 6 Other		IOVAI ITOM STATE	_ cen	netery, cret	ew G	eri	nany 1	letho	dist	t Ce	m. 11-	27-9	4 New	v Germany	, Mo
21. SIGNATURE OF FUNERA	AL SERVICE LI	CENSEE	1		1		22. NAME AI		SS OF FA	ACILITY					
100	27	re &	0,	12	1							npor	t. Mo	1. 21562	
23. PART I. Enter the dahock, or h	liseesea, or leart failure.	complications the	t ceuse	d the de	eth. Do r	not en								Approxima	
IMMEDIATE CAUSE (Findisease or condition resulting in death)	nei -	a. Can		E C	DUENCE O	751	hhy H	mix	5					Onset and	Death
Sequentially list conditions, leading to imme	diate	b	0	A CONSEC	DUENCE O	F):	Ar.	fen	Q	Ser	rep.				

24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 NO 1 YES 2 NO

11/25/5K

EFERREO TO MEDICAL	26. PLACE OF DEATH (Check only one)								
NO NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	DOA 4 12 h	ER: lursing Home 5 - Residence	6 Other (Specify)					
OEATH 5 Pending	280. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCURED					

NO X

D212 44

Investigation			1 L YES	2 NO	
Could not be determined	28e. PLACE OF INJURY — At he building, atc. (Specify)	me, farm, street, fac	tory, office		281. LOCATION (Street end Number or Rural Route Number, City or Town, State)

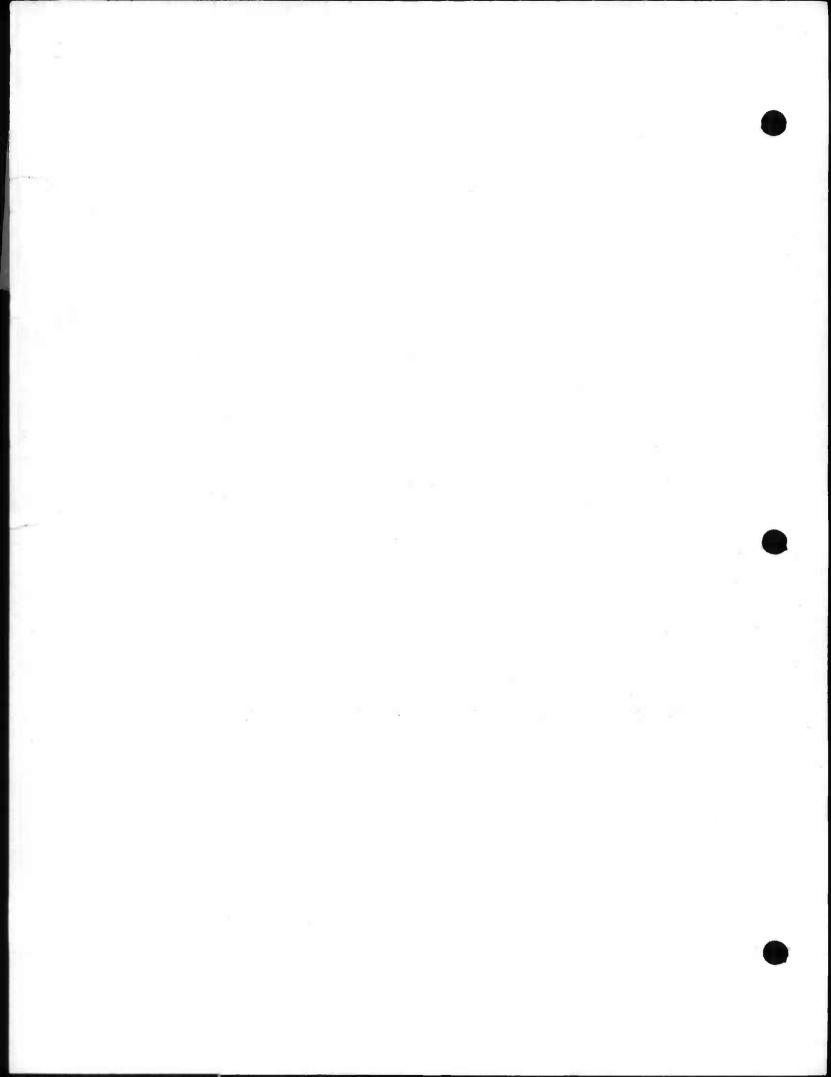
29e. CERTIFIER (Check only	1 DEPARTMENT OF THE DESCRIPTION
one)	2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated

2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in	my opinion, death occured at the time, date end place, a	nd due to the cause(e) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. OATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Jesus Tan M.D.	. Frostburg Plaza.	Frostburg,	Md.	21532
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE			

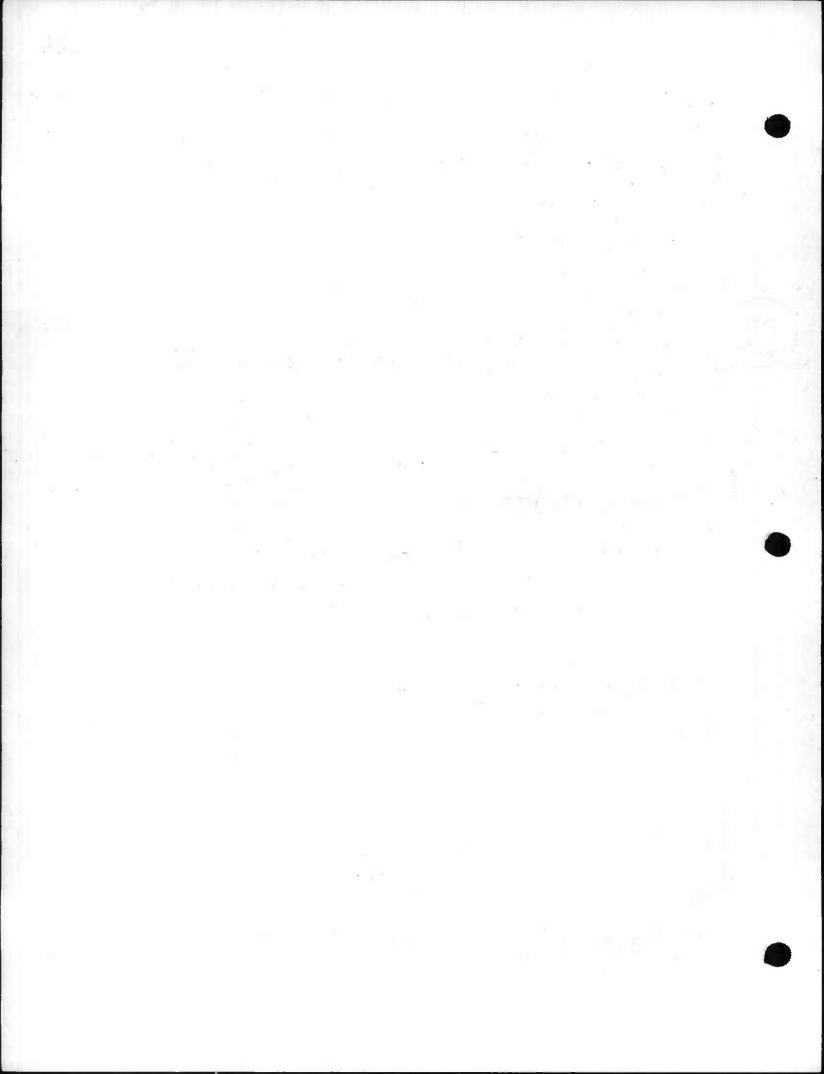
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DIVISION OF VITAL RECORDS, P.O. BOX 13146,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an income after death. Page 6 may be retained by the hose	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be mean be filed within 72 hours after death with the State Dept, of Meatth and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at one
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-transit permit. Pages 1, 2, 3 should

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AN CERTIFICATE OF DEATH	ID MENTAL	HYGIENE REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)	2. DATE O	F DEATH		3. TIME OF DEATH				
	Sister Lucille Moran	монтн Dec	. 6.	1994	4:55 PM				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HR	40.0 44	BIRTH Day, Year)		NPLACE (State or Foreign				
	220-44-3395' 1 M 2 F 93 YRS. MONTHS DAY'S HOURS MIN 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF	Aug.	19,1901		timore, MD				
DIRECTOR	Villa St. Michael Emmitsburg,			Frede	rick				
띭	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION				10d, INSIDE CITY				
	Maryland Frederick Emmitsburg,				1 X YES 2 NO				
AL	10e. STREET AND NUMBER 10f. ZIP COOE		10g. (CITIZEN OF	WHAT COUNTRY?				
E	333 South Seton Avenue 21727		U	.S.A.					
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECEMBENT OF HIS If yes, specify Cuban, Ma 1 YES 2 NO 1 YES 3 NO 1 YES 2 NO 1 YES 3	exican, Puerto Ric		Blac	E — American Indian, ck, White, etc. chy: White				
8	15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION	16b. F	INO OF BUSINESS	INDUSTRY					
RTED	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (Elementary/Secondery (0-12) College (1-4 or 5 +)	Rei	ligious	Commu	nitv				
rate i	College 5+ Business Administration		ughters						
000		S NAME (First, Mic	ddle, Malden Surnam	0)					
BE	William J. Moran Agne	es Gert	rude Cod	ori					
0	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Ri			Zip Code)					
-	Sister Camilla Harant 333 S. Seton Ave. Em			2172					
	20a. METHOD OF DISPOSITION 1 Startal 2 Cremetion 3 Removal from State 4 Donetton 6 Other (Specify) St. Joseph Provincia		20c. LOCATION						
			se Emmı	tsbu	rg,MD21727				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	OF FACILITY							
	William H. Ketteren Peters FH	I, Inc.	Gett	ysbu	rg, Pa.				
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	ı	with		Approximate interval Between Onset and Death				
CERTI	resulting in deeth) LAST								
PHYSICIAN: MEDICAL	PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Principle of the underlying cause given in Part I. 248. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 11								
A	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one)								
SIC	EXAMINER? HOSPITAL: OTHER: ence 6 🗆 Other	(Specify)							
ВУ РНУ	27. MANNER OF DEATN 1 Natural 5 Pending 28a. DATE OF INJURY (Month, Dey, Year) 2 Accident Investigation	28d. DESC	RIBE NOW INJURY	OCCURED					
	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCA City or	FION (Street and Nur Town, State)	mber or Rura	I Route Number,				
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and medical examination in the investigation, in my opinion, death occurred at				(a) and manner as stated.				
BE	296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE	L8 203	29d.	DATE SIGNE	19/94				
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
	31. DATE FILED (MONTE Day, Year) 1994 32. REGISTRANTS SIGNATURE		-						



DIVISION OF VITAL RECORDS, P.O. BOX 687604

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Thours after death. Page 6 may be retained by the hospital on the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		CERTIF	CATE OF	DEATH	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	INEZ LORRAIN	E MUSGRO	VE:			DECEMBER 2		YEAR 8.30 AM M	
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.				
E C	398-14-2236	1 🗆 M 2 💢 F 71	YRS.	JAN 18,19	8. SIRTNPLACE (State or Foreign Country) WISCONSIN				
	96. FACILITY NAME (If not institution, give str MONTGOMERY GENERAL			96 CITY, TOWN	OR LOCATION OF DE	ATN	9c. COUNTY OF DEATN MONTGOMERY		
DIRECTOR	RESIDENCE OF DECEDENT						1101	2001201(1	
Ϊ́	10s. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCA	TION			10d. INSIDE CITY	
늘	MD. MONTG	OMERY	BR	OOKEVIL	LE			1 YES 2 NO	
	10e. STREET AND NUMBER			T-10	f. ZIP CODE		10a CITIZE		
FUNERAL	22200 NEW HAMPSHI			20833			10g. CITIZEN OF WHAT COUNTRY? UNITED STATES		
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 YES	2 MNO	If yes, s		IIC ORIGIN? (Specify Yes n, Puerto Ricen, etc.)	or No-	4. RACE — American Indian, Black, White, etc.	
B	3 Widowed 4 Divorced	120, 2112 124, 011		1 1 1 1 1	2 25 NO Specify	<i></i>		WHITE	
0	15. DECEDENT'S EDUC		16e. DECEDENT'S			16b. KIND OF BUS	SINESS/INDUS	STRY	
	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of w	ork done during m e retired.)	ost of working				
COMPLET	2	Conege (1-4 or 5 +)	HOMEMAI	KER		OWN H	OME		
g ≥	17. FATHER'S NAME (First, Middle, Last)		1101111111		T 40 14071/1010 1111				
5 2	GEORGE THOMAS	~				ME (First, Middle, Maiden			
					SELMA	SIMONS			
2	19s. INFORMANT'S NAME (Type/Print)	***				Soute Number, City or Town			
	HARRY Z. MUSGROVE	JR.	22200	NEW HAI	MPSHIRE A	VENUE BRO	OKEVI:	LLE,MD.20833	
examiner must be notified at once. TO BE COM	20s. METNOD OF DISPOSITION 1 Suriel 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	val from State	metery, cremetory or of CARME	PEDISPOSITION (No. 1) THE PROPERTY OF THE PROP			CATION — CIT	ty or Town, State	
1	21. SIGNATURE OF FUNERAL SERVICE LICE	INSEE A		22. NAME A	ND ADDRESS OF FAC	CILITY			
	· marief H.	Bark	er			BER FUNERA 38 LAYTON			
medical	23. PART I. Enter the diseases, or co	omplications that cause	ed tha death. Do n	ot enter tha m	ode of dying, such	as cardiac or reepi	ratory arrea	it, Approximate	
E I	ahock, or heart fellure. L	let only one ceuse on	eech iine.					Interval Between	
	IMMEDIATE CAUSE (Finel disease or condition	PECDI	017001		111135			Onset and Death	
CVGIII,	resulting in death)	DUE TO (OR AS	A CONSEQUENCE OF	7 -	ILUEE			UA 95	
	disease or condition resulting in death) a. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): CHRONIC ORSTRUCTIVE LUNG DISEASE DUE TO (OR AS A CONSEQUENCE OF): CHRONIC ORSTRUCTIVE LUNG DISEASE DUE TO (OR AS A CONSEQUENCE OF): RUPTURED ABDOMINAL ADDIC ANEURYM ZWEET DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	Sequantielly list conditions,	DUE TO (OR AS	A CONSEQUENCE OF	VOIVE	LUNG	12/5EA	6	75173	
AT	if any, leading to immediate cause. Enter UNDERLYING	DUDE	IRED A	TRIVARIA	1141 A	ALTIC A	115/11	RYGUN ZINDA	
	CAUSE (Diseese or Injury that initiated events	DUE TO (OR AS	A CONSEQUENCE OF	1 DOPUL	VIIC ITC	JAIC N	10 201	1361 2000	
Ē	resulting in death) LAST			1.				j l	
	PART II. Other eignificent conditions	contributing to death	but not reculting is	n the underlyin	g ceuse given in	Part I. 24a. WAS AN	AUTOPSY	24b. WERE AUTOPSY FINDINGS	
EDICAL	A 1 A 1	MELLI				PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE	
ED		111000	, , ,			1 _ YES 2	PICNO	OF DEATH?	
ŽΙΣ	DID TODA CCO LICE CC	Internal						1 TES 2 NO	
A N	DID TOBACCO USE CONTR	IBUTE TO CAUSE (1 L			
히	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEAT	H (Check only one, OTHER:					
YSICI/	1 TYES 2 X NO	1 Inpatient 2 ER/Ou	tpatient 3 DOA		ne 5 🗆 Residence	6 Other (Specify)			
	27. MANNER OF DEATN	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME INJU	OF 28c. IN	JURY AT ORK?	26d. DESCRIBE NOW II	NJURY OCCU	RED	
ВУ РН	1 Natural 5 Pending 2 Accident Investigation	, , , , , , , , , , , , , , , , , , , ,			YES 2 NO				
	3 Suicide e Could not be	28e. PLACE OF INJUR	Y — At home, term, s	reet, factory, offic	:0	281. LOCATION (Street s	nd Number or	Rural Route Number,	
TED	4 Nomicide detarmined	building, atc. (Sp.	sciry)			City or Town, State)			
	29s. CERTIFIER , NO CERTIFYING PHYSIC	IAM. To the base of	147 P 4 - 5-						
BE COMPLETED	(Check only T D CERTIFYING PNYSIC	IAN: To the best of my kno : On the basis of axaminati						cause(s) s <i>nd</i> manner as stated.	
	296. SIGNATURE AND TITLE OF CERTIFIER	1			29c. LICENSE NUM	BER	29d. DATE S	SIGNED (Month, Day, Year)	
	cexten U.	Fono (D154	15	_	RC. 2, 1994	
12	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF D	EATH (ITEM 27) (Type	Print)	2.07	V 3	1	2,117	
	DR. CEZAR A. LOPE	Z 18111 PR	INCE PHIL		E OLNEY,	MD. 208	332		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SU	ATHRELL						
	DEC 12 1994	che commende							

a place of the same = = ,2.3 V- ---

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and recent control of the control of t BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

_	ricolo (Traff				OLITTI	IVAI		DEA		HEG. NO.			
ş	1. DECEDENT'S NAME (First,	an element								2. DATE OF DEATH MONTH DA	NY .	YEAR	3. TIME OF DEATH
		ILLSWOE		AFEE				-		DECEMBER	2,	1994	3:15 A M
	4. SOCIAL SECURITY NUMB		5, SEX		s. last birthday)	IF UNDER	DAYS	HOURS	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHI Country	PLACE (State or Foreign
	219-14-815		1 🔀 M 2 🗌 F	70	YRS.					JAN. 5, 1	924	M	ARYLAND
œ	98. FACILITY NAME (If not in	-	•			9b. CITY		OR LOCATIO			9c. COU	NTY OF DE	HTA
ᅙᅵ	4909 MT. E		ROAD					KEED!	YSVII	LLE		WAS	HINGTON
DIRECTOR	10e. STATE	10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	TION					10d. INSIDE CITY
	MARYLAND	WA	ASHINGTON	1			KE	EDYS	/ILLE	Ξ			LIMITS? 1 YES 2 X NO
¥	10e. STREET AND NUMBER						101	f. ZIP CODI	E		10g. CIT	IZEN OF W	HAT COUNTRY?
FUNERAL	4909 MT. BF	IAR RO						2	21756	5		U.	S.A.
	11. MARITAL STATUS 1 Never Married 2 X	Married	12. WAS DECEDEN FORCES? 1	TEVER IN U.S	NO NO	13.	WAS DEC	ENDENT C	F HISPAN	IC ORIGIN? (Specify Years, Puerto Rican, atc.)	or No-	14. RACE Black	American Indian, White, etc.
B	3 Widowed 4 Divo	170772	IF YES, GIVE W	WAR				2 💢 NO				Specif	WHITE
	15. DEC	EOENT'S EDUC	CATION		. DECEDENT'S	USUAL O	CCUPATIO	ON		16b, KIND OF BUS	SINESS/IN	OUSTRY	WHITE
	(Specify only Elementary/Secondary (0	highest grade	College (1-4 or 5	P)	(Give kind of life. Do NOT u	work done se retired.)	during mo	st of working	g				
AP	8				AS	SEME	BLER			VENDING	MAC	HINE	MANUFACTURE
COMPLETED	17. FATHER'S NAME (First, M							18. MOTE	HER'S NAI	ME (First, Middle, Maiden	Sumame)		
BE	THOMAS E.							FAN	NIE	CAROLINE H	EETS	3	
0	19a. INFORMANT'S NAME (7									loute Number, City or Tow			
	ANNABELLE 1			1000					AD,	KEEDYSVILI			1756
	1 X Buriel 2 Cremetto 4 Donetton 5 Other	n 3 🗆 Remo	oval from State		CE AND DATE				NDV			City or Tov	vn, Stata , MARYLAND
	21. SIGNATURE OF FUNERA		ENSEE	1 (11)	AIT LIAN			ND ADDRES			GERS	TOWN	MARILAND
	DE 01	na li	1	Paul M	. Dean			FUNE		HOME: 7606			lonal Pike
-	Jan Part Form	11-16	av							Boon		o, M	21713
No	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) S. Carrino was of Liver b. Carrino was of Liver												
HIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
CH CH	resulting in deeth) LAS	T (. <u>[]</u>	abe	tes	p	121	li 7	ry				
	PART II. Other eignifice	nt condition	e contributing to	death but n	ot reculting	In the u	nderlyin	g ceuee ç	given in i	Pert I. 24s. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL										1 YES 2	NO		COMPLETION OF CAUSE OF DEATH?
Σ										- '			1 - YES 2 10
CIAN	25. WAS CASE REFERRED TO	MEDICAL					20 01	ACE OF D	EATH (CL.	ick only one)			
2	EXAMINER?		HOSPITAL:	ER/Outnotier	w 3 □ DOA	OTHE	R:			8 Other (Specify)			
TH YS	27. MANNER OF DEATH		28s. DATE OF	INJURY	28b. TIN	E OF	28c. INJ	URY AT	Isiderica	28d. DESCRIBE HOW II	INJURY OCCURED		
2		Pending Investigation	(Month, D	ay, rear)	in.	JURY M		PRK? YES 2	NO				
- 11	3 Suicide 8	Could not be	28a. PLACE O	F INJURY A atc. (Specify)	t home, term,	street, tac	tory, offic	a		28f. LOCATION (Street a City or Town, State)	nd Numbe	r or Rural A	oute Number,
	4 Hornfelde	determined											
COMPLEIED										to the cause(a) and mar			
5	2 MEDI	CAL EXAMINE	R: On the basis of e	xamination and	d/or investigation	on, in my	opinion, d	leath occur	ed at the	time, data and place, an	d due to t	ha cause(a)	and manner as atated.
O BE	286. SHOMATURE AND ATLE	ay	ne M	1				29c/LICE	35 NUM	997'	29d. DAT	Z ·	(Month, Day, Year)
	7.A. 4/1	SHA	2 M	1 3	76	Print)	10	< 5	57	. HAGE	Rs	178	wow HB
	31. DATE FILED (Month, Day,	Year)	32. REGISTRA	R'S SIGNATUR	RE	ř.							21740
_^	- 19	34 6		The second second	1000								DHMH-16 Rev 1/89

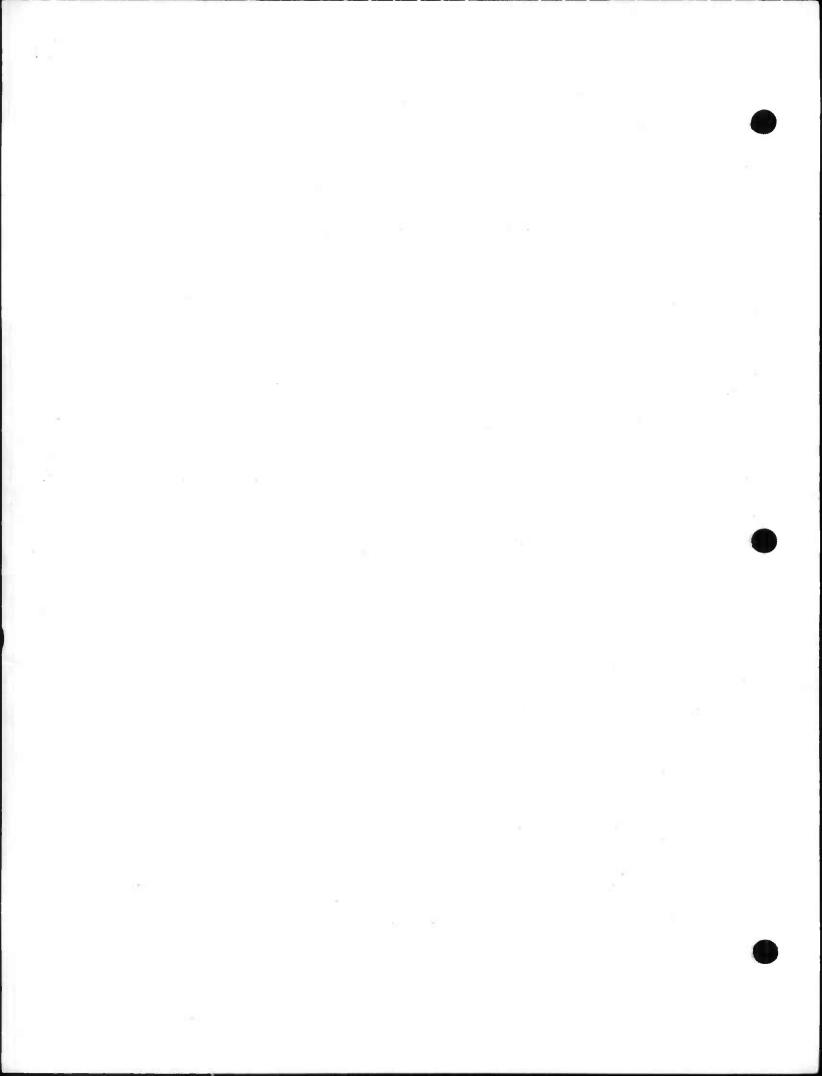
DIVISION OF VITAL RECORDS, P.O. BOX 68760

burs after death. Page 6 may be retained by the hospital or attending physician. In by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should once. Ħ notified be must medical examiner 9 filled in and completely fille to burial, cremation, the traumatic event, requires that the death certificate be executed with physician Hygiene prior other 0 been signed by the attent. of Health and Mental injury, shows any has be Dept. HOSPITAL OR ATTENDING PHYSICIAN: The law 23 Hem certificate to the State 0 the this c marked, After 1 DIRECTOR: At hours after de Item 28 is r FUNERAL I within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AN REGISTRAR Thomas William Martin CERTIFICATE OF DEATH STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1994 3. Dec. noma 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH Oct. 20, 1910 DAYS HOURS 705-10-4667 1 M 2 - F 84 Maryland YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 13640 Village Mill Drive Maugansville Washington RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Washington Maugansville 1 YES 2 NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 13640 Village Mill Drive 21767 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried BY Specify: 3 Wildowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INOUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 9 boiler maker W. Md. Railroad 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) LLoyd Wider Martin Lottie Luvene Hart BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Dolores J. Mauck Maugansville, Maryland 21767 13640 Village Mill Drive 20a. METHOD OF DISPOSITION
1

☐ Burlel 2 ☐ Cremetion 3 ☐ 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State DATE Lawn Memorial Park 4 Donation 5 Other (Specity) Cedar 12/6 Hagerstown, Maryland TURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Gerald N. Minniah 305 N. Potomac Street Funeral Home Hagerstown, Maryland 23. PART I. Enter the disease, or complicatione that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heert fellure. List only one ceusa on each line Interval Between Onset and Death IMMEDIATE CAUSE (Fine) disesse or condition elogenous 6 weeks ile resulting in death) OUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentisity liet conditions. DUE TO (OR AS A CONSEQUENCE OF): If sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPS WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO PHYSICIAN: NO M DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: 1 | Inpatient 2 ER/Outpatient 3 | DOA 4 Nursing Home 5 8 Other (Specity) 27. MANNER OF DEATH 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident Investigation Sulcide 28s. PLACE OF INJURY — At home, farm, atreet, fectory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Trum, State) 8 Could not be determined COMPLETED 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the b SIGNATURE AND TITLE OF CERTIFIER 29¢ LICENSE NUMBER 29d. OATE SIGNED (Month, Day, BE 9 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, a a OLD Y 0 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE DEC 05 1994



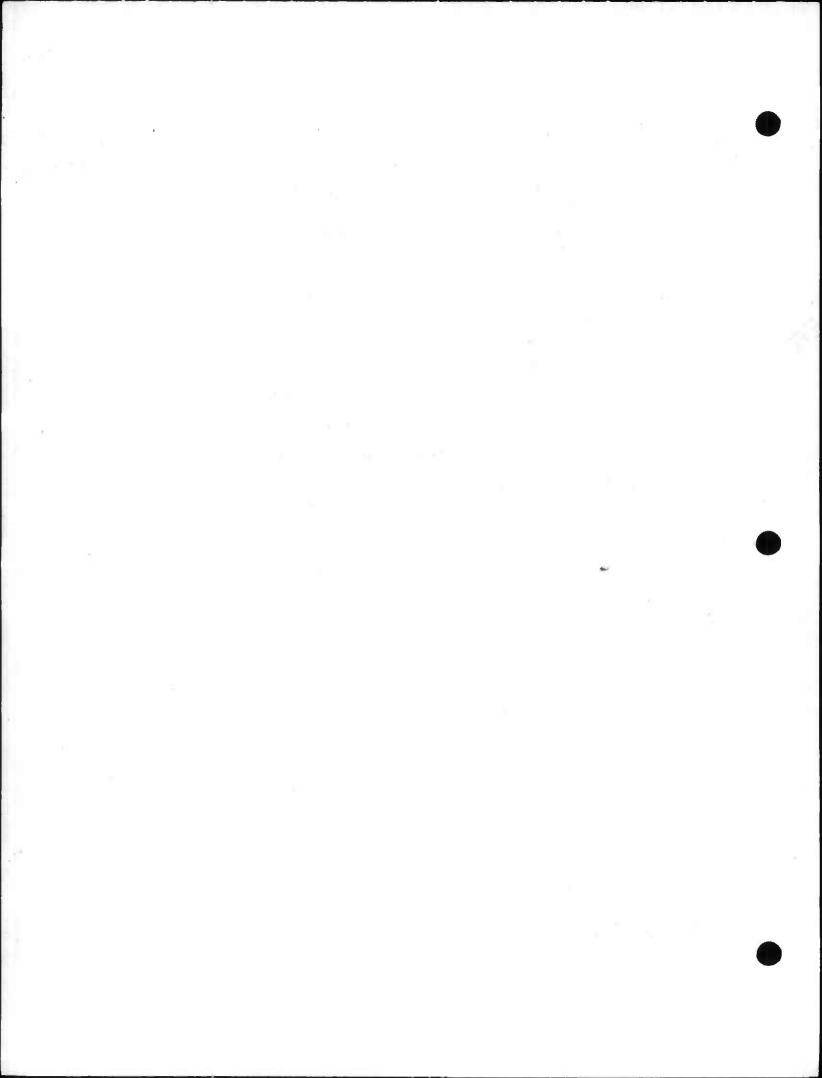
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	3. TIME OF DEATN				
	Sara Elizabe	th		MURPHY	1 1 0 1 1	994 8:10 P M				
	The American Control			F UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)	8. BIRTNPLACE (State or Foreign Country)				
		1□ M 2 💢 F 80	YRS.		11-26-1913	Del.				
~	9e. FACILITY NAME (If not institution, give stree		9	b. CITY, TOWN OR LOCATION OF I		DUNTY OF DEATN				
DIRECTOR	Wesleyan Health C	enter		Denton Md. 21	629 Ca	roline				
JEC	10a, STATE 10b, COUNTY		10c. CITY,	TOWN OR LOCATION		10d. INSIDE CITY				
	Md. Caroli	ne	G	reensboro		1 TYES 2 TO NO				
14 AL	100. STREET AND NUMBER			10f. ZIP CODE	10g. C	CITIZEN OF WHAT COUNTRY?				
FUNERAL	12230 Knife Box Rd			21639		J.S.A.				
	11. MARITAL STATUS 1 Never Married 2 Married	2. WAS DECEDENT EVER IN FORCES? 1 YES	2 X NO	If yes, specify Cuban, Maxic		Black, White, etc.				
ВУ	3∑∑ Widowed 4 □ Divorced	IF YES, GIVE WAR OR DA	итея Х	1 TYES 2 NO Spec	lfy:	Specify: White				
ED	15. DECEDENT'S EDUCAT (Specify only highest grade co.	(ION mpleted)	16a. DECEDENT'S US	SUAL OCCUPATION is done during most of working	16b. KIND OF BUSINESS/I	INDUSTRY				
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use i	retired.)						
MP	8		Proce	ssing		Processing				
	17. FATNER'S NAME (First, Middle, Last) John Gibbs				AME (First, Middle, Meiden Surname)				
B	19a. INFORMANT'S NAME (Type/Print)		195. MAILING A		Tibbett Route Number, City or Town, State.	Zin Code)				
2	Betty Gibson				Henderson Md.	-,,				
	28a. METNOD OF DISPOSITION X□ Buriel 2 □ Cremation 3 □ Remove		PLACE AND DATE OF	DISPOSITION (Name of		— City or Town, State				
	4 Donation 5 Other (Specify)		etery, crematory or othe rove Ceme	tery 11-4	- 94 Preston	Md.				
	21. SIONATURE OF FUNERAL SERVICE LICEN	ŞEE		22. NAME AND ADDRESS OF F						
	Merch (- flue	>	P 0 Poy 160	Greensboro Md	21620				
	23. PART I. Enter the diseases, or cor shock, or heart failure. Lis	nplications that odused	the death. Do not	enter the mode of dying, su	ch sa cerdiec or respiratory	arreet, Approximata				
l l	IMMEDIATE CAUSE (Finel			(Conco)	1	Interval Between Onset end Daath				
	diseese or condition resulting in death) e.			c Cancel		Tras				
	DUE TO (OR AS A CONSEQUENCE OF):									
ON O	Sequentielly list conditions, If any, leeding to immediate									
A	cause. Enter UNDERLYING	3330	,			İ				
Ē	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION	resulting in deeth) LAST									
AL C	PART II. Other aignificent conditions	contributing to deeth b	ut not resulting/in	the underlying ceuse given in						
2)123e	res !	1011	NS	PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATN?				
핗						1 TYES 2 NO				
ä										
PHYSICIAN: MEDIC		IOSPITAL:		28. PLACE OF DEATH (C	heck only one)					
17S	1 VES 2 NO 1	28a. DATE OF INJURY	etlent 3 DOA 4	Nursing Nome 5 - Residence						
	1 Netural 5 Pending	(Month, Day, Year)	28b. TIME (28d. DESCRIBE NOW INJURY C	CCURED				
ВУ	2 Accident Investigation 3 Suicide & Could not be	28a. PLACE OF INJURY	- At home, farm, stre		2ef. LOCATION (Street and Numb	ber or Rural Boute Number				
回	8 Could not be 4 Nomicide determined	building, etc. (Spec	rfy)		City or Town, State)					
J.E	29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my know!	edge, death occurred	at the time, date end piece, and du	e to the cause(s) and menner as a	stated.				
COMPLETED						the couse(s) and menner as stated.				
	296, SIGNATURE (ND) TITLE OF CERFIFTER		~	29c. LICENSE NU	JMBER 29d. D.	ATE SIGNED (Mghth, Day, Year)				
TO BE	Huy W.	in	64	1440	1058	11/2/84				
F	30. NAME AND ADDRESS OF PERSON WHO	OMPLETED CAUSE OF DE	ATN (ITEM 27) (Type, Pr		4.4	7 /				
	31. DATE FILED (Month, Day, Year)	12 DECISTRADE SIGN	DOX 127	- Goldsbor	D MD 211	036				
	NOV 0 7 '94	Sin Druidson	-Randopa			}				
			1							



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TOWN THE THE PARTY AND THE OF	O BE COMDIFTED BY BUYCLOIAN. MEDICAL OFFICE ATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
ie.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
he funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should	TO THE FUNERAL DIRECTOR: After this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit, Pages 1, 2, 3 should
r death. Page 6 may be retained by the hospital or attending physician.	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			ENTAL HYGIEN				
i	1. DECEDENT'S NAME (First, Middle, Last)					DATE OF DEATN		3. TIME OF DEATH		
	Bertie Dorothy	Wilson	Nu	tter	be	ecember 5	1994	1:12 P M		
- 3	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR	IF UNDER 24 HRS. 7	Month, Day, Year)	8. BIR	TNPLACE (State or Foreign ntry)		
~	219-05-3337 A	1 M 2 F	91 YRS.	THS DAY®	HOURS MIN.	ept. 6, 1				
	9a. FACILITY NAME (If not institution, give str	eet and number)	96	CITY, TOWN OF	LOCATION OF DEAT	Н	9c. COUNTY OF	DEATH		
DIRECTOR	Red Hill Road (Re	sidence)		Indian_	Head		Char1e	es		
EC	10a. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCATION	ON			10d. INSIDE CITY		
급	Pennsylvania Phil	adelphia	Phi	ladelph	nia			LIMITS?		
FUNERAL	10e. STREET AND NUMBER				ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?		
Ë	1213 North 56th	Street			19131		USA	A		
FU	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEOENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DECE	NOENT OF HISPANIC	ORIGIN? (Specify Yas	or No- 14. RA	CE — American Indian, ick, White, atc.		
ВҰ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES L		NO Specify:	, ,	Spe	Black		
	15. DECEDENT'S EDUC	ATION	16a. DECEDENT'S USU	IAL OCCUPATION	N	16b. KINO OF BUS	I SINESS/INDUSTRY			
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of work life. Do NOT use re	done during most tired.)	of working					
MPL		2	Teacher/D	omestic	Work	Educati	on/Priva	ate		
00	17. FATHER'S NAME (First, Middle, Last)	4				(First, Middle, Maiden				
BE	James Addison Wi	Ison			Laura El			ו		
2	19m. INFORMANT'S NAME (Type/Print) Louise N. Thomas				d Number or Rural Rou Indian He					
	20m. METNOD OF DISPOSITION		PLACE AND DATE OF D			OATE 20c. LO	20640			
	1 💢 Burial 2 🗆 Cremation 3 🗆 Ramo 4 🗆 Donation 5 🗆 Other (Specify)	val trom Stata Corp.	etery, crematory or other life Chape	1 Memor	ial Park	12/12 Fe	astervi	lle, Pennsylv		
	21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE		22. NAME AND	ON S FUN	TY HOME		, 101110/21		
	Leon Thornton	0	•	1				20670		
	23. PART i. Enter the diseesea, or co		the deeth. Do not		BOX 115			Approximate		
	ahock, or heart feiture. L	ist only one cause on e	ech line.				, , , , , , , , , , , , , , , , , , , ,	interval Between Onset and Death		
- 1	disease or condition resulting in death)	CANC	ER 0	-	COLON			11/94		
	a death)	DUE TO (OR AS A	CONSEQUENCE OF):					1 11		
N	disease or condition resulting in death) a. CAFCER OF COLON Due to (or as a consequence of): Liver METS Sequentially list conditions, DIE TO (OR AS A CONSEQUENCE OF):									
Ĭ.	if any, leeding to immediate course. Enter UNDERLYING									
임	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):							
CERTIFICATION	resulting in deeth) LAST									
	PART II. Other significent conditions	contributing to death b	ut not requiting in th	a undarlular	seure alves la Re	-1 A. MARAN	истовои Га			
CAL	The state of the s	contributing to death of	at not resulting in ti	ie ungerlying	ceuse given in Pa	rt i. 24a. WAS AN PERFOR		No. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE		
EDI						_ 1	□ NO	OF DEATN?		
Σ.	DID TOBACCO USE CONTR	IRLITE TO CAUSE O	F DEATH YES		UNCERTAIN	_		1 TES 2 NO		
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF OEATN (C		DITCERIAIT	<u> </u>				
SIC		HOSPITAL: 1 Inpetient 2 ER/Outp		HER: Nursing Nome	5- Rasidence 8	Other (Specily)				
E	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJUI WOR	RY AT 26	Bd. DESCRIBE NOW I	NJURY OCCURED			
BY	1 Natural 5 Pending 2 Accident Investigation			M 1 TYE						
ED	3 Suicide 8 Could not be 4 Nomicide datermined	28a. PLACE OF INJURY building, atc. (Spec.	— At homa, farm, atree f(y)	t, factory, offica	28	Bt. LOCATION (Street a City or Town, State)	and Number or Rura	l Route Number,		
Ē	no- centicien /									
COMPLET	(Check only CERTIFYING PNYSIC	IAN: To the best of my knowl								
S		On the basis of examination	and/or investigation, in	my opinion, dea	ith occured at the tim	e, data and placa, an	d due to the cause	r(a) and manner as stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIER	Ma Ma	100		29c. LICENSE NUMBE	R	29d. DATE SIGNE	D (Mogth, Day, Year)		
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OF	ATN (ITEM 27) (Tune Prin		D-28352	<u> </u>	0 :	010		
	Krishan Mathur, M	_	(11340	Pembrook			213		
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	ATURE 0	waluo	II. Mary	Lanu ZUOU	<u>J</u>			
	DEC 0 6 1994	32. REGISTRAR'S SIGN	ion Randall							

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1 - FOR STATE REGISTRAR

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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH TOHN ERNEST NUSZ 1045AH 27/ 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF IMOER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 212-24-6359 1 M 2 - F HOURS Dec. 10, 69 YRS. 1924 Maryland burial-transit permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1505 West Patrick Street Room 18 DIRECTOR Frederick Frederick RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Frederick Frederick 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1505 West Patrick Street Room 18 21701 United States within 24 hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Pu 1 TYES 2 NO BY Specify: 3 Widowed 4 Divorced for use as the 1941-1944 White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY dary (0-12) Elementary/Secon College (1-4 or 5+) detached 12 Self-employed Junk Business at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) the funeral director, page 5 should be Henry E. Nusz BE Vivian E. Ritter notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Teresa Wood 477 School Street Cloverdale, CA 95425 pe 20s. METHOD OF DISPOSITION
1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must Hagerstown Crematory 12/3/94 Hagerstown, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEET 22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A 1621 Opossumtown Pike Frederick, MD or removal. medicai 23. PART I. Enter the disesses, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. this certificate has been signed by the attending physician and completely filled in by I with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remo Approximata intarval Between IMMEDIATE CAUSE (Final Onset and Daath the disease or condition ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): executed other traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING death certificate be CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEDUENCE OF): that initiated events resulting in death) LAST PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS any AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO shows a 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) The HOSPITAL: OTHER:
4 □ Nursing Home 5 CRasidence 8 □ Other (Specify) 1 X YES 2 NO OR ATTENDING PHYSICIAN: 1 | Inpetient 2 | ER/Outpetient 3 | DOA 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, 1 🔀 Natural 5 Pending 1 YES 2 NO BY FUNERAL DIRECTOR: After within 72 hours after death 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 28 4 Homicide Item 29a. CERTIFIER (Check anly 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. HOSPITAL IMPORTANT: If 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER

RELECTION

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BE 29c. LICENSE NUMBER THE D09867 299 2 1994 32. REGISTRAR'S SIGNATURE RANGELL Frederick Md 21701-4599

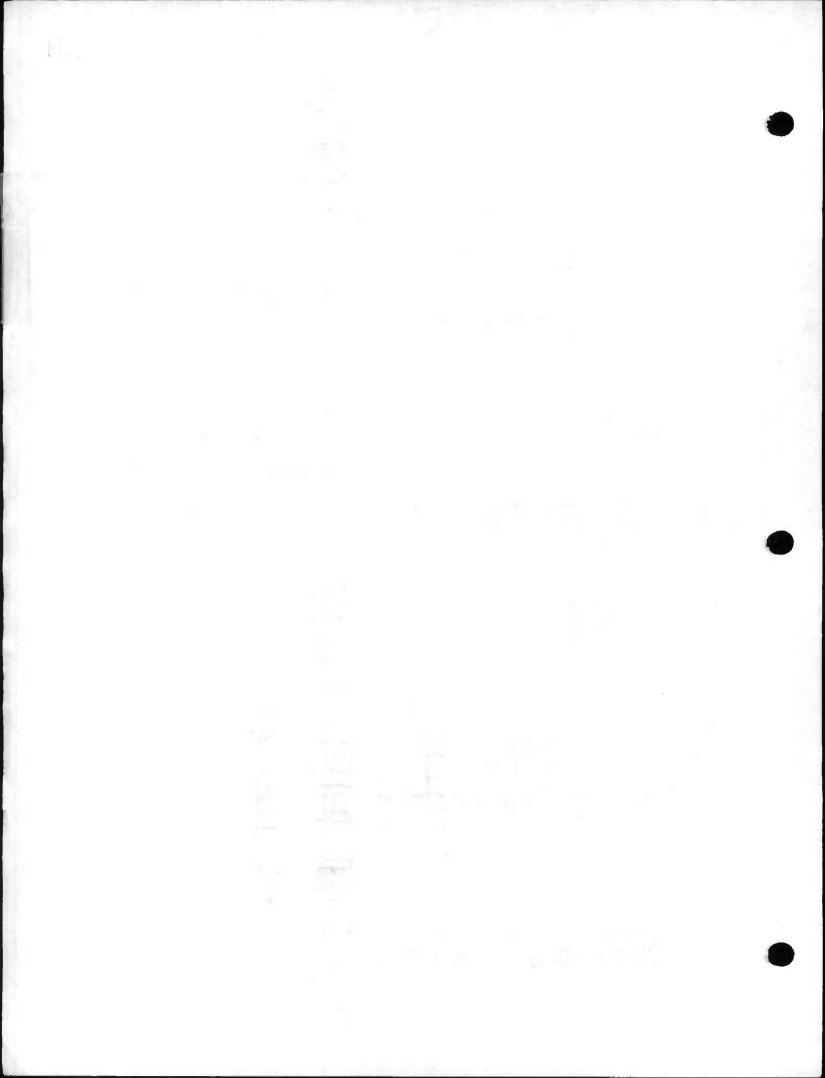
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

94 37051 Montgomery Amended # 10e # 12 # 199 11/30/94 MRT

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

	TIEGIOTTOWT				IOAIL	- 01	DEA		HEG. NO				
	1. DECEDENT'S NAME (First, Middle, Last) EOIN MacI	onald Ny		C				2. DATE OF DEATH DAY YEAR NOV. 28. 1994			3. TIME OF DEATH 5.15 P.M.		
- 1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH		BIRTH	PLACE (State or Foreign	
1	030-09-1443	81	YRS.	MONTHS	DAYS	DAYS HOURS MIN.		JUNE 14,1	Country)		SACHUSETTS		
	9a. FACILITY NAME (If not institution, give s	treet and number)			96. CITY	TOWN	OR LOCATI	ON OF O	EATH	9c. COI	JNTY OF D	EATH	
DIRECTOR	Fernwood Nursing	Home			Ве	the	sda			Mon	ntgom	ery	
	10a. STATE 10b. COUNTY	1		10c, CIT	Y, TOWN C	OR LOCA	TION					10d. INSIDE CITY	
		NGTON			INGT	ON						10d, INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	1637 NORTH GREENB	RIER STR	EET				2205					STATES	
3	11. MARITAL STATUS		NT EVER IN U.S. AF						NIC ORIGIN? (Specify Ye	s or No-	14. RACE	— American Indian, c, White, atc.	
	1 Never Married 2 Married		NAR OR DATES				ecify Cubi		n, Puerto Rican, etc.)		Black	c, White, atc.	
B	3 Widowed 4 Divorced		NWTE				A A NO	Specif	у.		CĂŬ	OCCHY: UCASIAN	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION	18a. DE	CEDENT'S	work done	CCUPATI during m	ON ost of worki	ing	16b. KINO OF BU	SINESS/IN		O. M. M. M.	
ᄪᆡ	Elementary/Secondary (0-12)	College (1-4 or 5	- Itte	. Do NOT us	se retired.)								
<u>a</u>		5 +	LNDI.	ISTRI	AL E	CONC	MIST	1	COMMERC	E DE	PART	MENT	
5	17. FATHER'S NAME (First, Middle, Lest)					ME (First, Middle, Maiden							
	IOGERNI AT DERM	CANTIDON	3 13 TT 1773 T				264	DIZ T	TTTT 122 16 T	ONTAX	70		
JOSEPH ALBERT CAMERON NYHEN 1900 INFORMANT'S NAME (Type/Print) 1900 MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code)													
ဥ	190 INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRESS	S (Street	and Numbe	r or Rural	Route Number, City or Tow	vn, Stata, Z	(Ip Code)		
	GAMERON DARBY-NYH	EN	1	643	NO.	GREF	NBRT	ER S	TREET, ARI	INGT	ON.	VA. 22205	
	20a, METHOD OF DISPOSITION		20b. PLACE	ANO DAT							- City or To		
	1 Surial 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	ovel from State	of cemetary	crematory	or other p	lace)	T CE	nationiti	RY12/7/95	ADT T	אזכידים:	NI VITOCINITA	
	21. SIGNATURE OF FUNERAL SERVICE LIE	www.	ARLIN	AGTOM			ND ADDRE			AKLI	NGIU	N. VIRGINIA	
- 3	1. Sidning Tonesiae Service Co.	X /			**.	NAME A			UNERAL HON	ATT I	INC		
	I Los ding	10/10	ruer)									
	22 PART I Seter the diseases of				ant anta-	dha m			N. VIRGIN			I. Assessationed	
												Approximata Interval Batween	
	IMMEDIATE CAUSE (Finel										Onset and Death		
	disease or condition											m 70	
	resulting in death) a. Due to (or as a consequence of):										Monne		
	DOE TO (ON AS A CONSEDURINE OF):											11.0	
Z	Sequenticity list conditions, b. Melaslabic oby town											years	
Ĕ	if eny, leading to immediate	eny, leading to immediate											
CERTIFICATION	CAUSE (Disease or Injury	C.											
E	that initiated events	DUE TO	OR AS A CONSE	GUENCE O	f):								
1	resulting in daeth) LAST												
8		d											
	PART ii. Other significent condition	s contributing to	death but not	resulting	in the u	nderlylr	ig cause	given in			246	. WERE AUTOPSY FINDINGS	
3										RMED?		AVAILABLE PRIOR TO	
EDICAL						-			1 TYES	2 🗌 NO	- 1	OF DEATH?	
ME												1 YES 2 NO	
											1		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL			8		26. F	LACE OF	DEATH (C/	heck only one)				
2	EXAMINER?	HOSPITAL:	- Landonie VI		OTHE		100		dui_n_avenue				
\ ×			☐ ER/Outpetient					lesidence	8 Other (Specify)				
H	27. MANNER OF DEATH	28a. DATE O (Month,	F INJURY Day, Year)	26b. TIM	IE OF JURY	28c. IN	JURY AT ORK?		28d. DESCRIBE HOW	INJURY O	CCURED		
ВУ	1 Natural 5 Pending				M	1 🔲	YES 2	□ NO					
	a Dutate		OF INJURY - AI h	ome, farm,	street, fac	tory, offi	CB	-	281, LOCATION (Street	end Numb	er or Rural i	Route Number,	
8	4 Homicide 6 Could not be detarmined	building	i, atc. (Specify)						City or Town, State	9)			
COMPLETED									L				
7	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best o	of my knowledge, d	eath occur	red at the	lime, dat	e and plac	e, end du	e to the cause(e) and mi	enner se si	tated.		
Σ	one) 2 MEDICAL EXAMINI	ER: On the basis of	examination end/or	Investigation	on, In my	opinion,	death occi	ared at the	lime, data and place, a	nd dua to	the cause(s) and menner as stated.	
	29b. SIGNAZURE AND TITLE OF CERTIFIE			_									
BE	296. SIGNAPURE AND TITLE OF CERTIFIE			_ ^			29c. LIC	ENSE NU	MBER	Liberton and		(Month, Day, Year)	
	Russell M.	Ille	-JK	M	· Q,		D	1188	8		Nov.	28,1994	
5	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED OA	USE OF DEATH (ITE	EM 27) (Type	e, Print)								
	Puggoll Tiller	M.D. 4.70	1 74 6										
	Russell Tillev.] 31. DATE FILEO (Month, Day, Year)	M.D. 470	Mass A	ve ,	N M	Was	ning	ton,	D.C. 2001	.6			
	NOV 3 0 1994	A D. I	Pavidson-Ra	mde 00				Ĭ					
	DPPLU & VIIN	June 1	and assov-Na	1 Indo	•								



1 - FOR STATE REGISTRAR

		1. DEGEOENT'S NAME (FIRST, M		1	/EAL			2. DATE OF DEATH DAY YEAR OF THE PROPERTY OF T			3. TIME OF OEATH A		
6 2/4		4. SOCIAL SECURITY NUMBER 169-30-6369	R	5. SEX 1 XM 2 TF	AGE (In yrs. I		7	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, D May 2		Coun	HPLACE (State or Foreign try) necticutt	
2, 3 should	OR	9a. FACILITY NAME (II not institute of the prince of the p	E HOS		TER					9c.	COUNTY OF		
020 physician. burial-transit permit. Pages 1, (DIRECTO	RESIDENCE OF DECE								10d. INSIDE CITY LIMITS?			
semit.	AL D	NA 100. STREET AND NUMBER	NA			Washin		D.C.		10g	. CITIZEN OF	1 YES 2 NO WHAT COUNTRY?	
an. ransit p	1 1111	1501 19th St	.,S.E					20020		υ	nited	States	
215-0020 attending physician ise as the burial-tra	BY FUN	11. MARITAL STATUS 1 Never Merried 2 X M 3 Widowed 4 Divorce		FORCES? 1X	See See	2 X NO Specify: Sou				E — American Indian, ck, White, atc.			
r attending	TED	15. DECED (Specify only h	ENT'S EDUC	CATION completed)	(Give kind of work dor	ne durina me	ION ost of working	16b. KI	ND OF BUSINES	S/INDUSTRY		
AND 21 the hospital or detached for u	COMPLET	Elementary/Secondary (0-12		College (1-4 or 5+)			,		U.:	S. POST	OFFI	CE	
3 & & Z	ш	17. FATHER'S NAME (First, Midd ISAAC JONE	,,					18. MOTHER'S NA PEARL E			me)		
MAR retained 5 should notified	10 B	19a. INFORMANT'S NAME (Type AUDREY NEAL	s/Print)	/UTEE)	1						. ,		
		20a. METHOD OF DISPOSITION					Shing	ton, D.					
AORE may lirector, pag		1/\(\) Burial 2 \(\) Cremation 4 \(\) Donation 5 \(\) Other (S)		oval from Stata	cemetery, ci	rematory or other place	el		2/7			1ARYLAND	
ALTIMORE, death. Page 6 may be funeral director, page		21. SIGNATURE OF FUNERAL S	SERVICE LIE	NAME AND ADDRESS OF THE PARTY O		M859	ALEX/	ANDER S.	POPE I	FUNERAL	HOMES	- >C+ >C-	
BAnours after of in by the or removal.		23. PART I. Enter the dise	ases, or c	omplications that co	aused tha d	asth. Do not ent	ar the mo	oda of dying, such	h ss cardiac	or respirator	Y LLLLy arrest,	Approximate	
tely fille mation.		IMMEDIATE CAUSE (Final disease or condition resulting in death) s. Corresponding to the condition of the co											
	NO	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury										seem	
O P P P P	-ICATION												
	CERTIFI	resulting in death) LAST	Į,	1.		Total or j.							
DS the d we dinjur	EDICAL (PART II. Other significant	condition	s contributing to da	ath but not	rasulting in tha	undariyin	g cause givan in	Part I. 24	a. WAS AN AUTO	PSY 24	D. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE	
RECOR w requires that been signed by or. or Health an shows any	MEDI								_ 1	YES 2	OF DEATH?		
L Flaw I law	AN	DID TOBACCO USE 25. WAS CASE REFERRED TO M		RIBUTE TO CAUS					1 🗆				
F VITAL SICIAN: The la certificate has the State Dep	PHYSICIAN:	EXAMINER?		HOSPITAL:		ОТН	ER:		6 Other (S)	pecify)			
OF PHYSIC this cer with th		27. MANNER OF DEATH	nding estigation				WC		28d. DESCRIBE HOW INJURY OCCURED				
U 5 4 5 "	red BY	3 Suicide 8 Co	uid not be	26a. PLACE OF IN building, etc.	JURY — At h (Specify)	ome, larm, street, li	ictory, offic	Ca .		ON (Street and Nu own, State)	imber or Rural	Route Number,	
DIVISION AL DR ATTENIAL DR ALL DIRECTOR: 72 hours after If Item 28 is	COMPLET												
	CON			R: On the beals of axem	instion and/or	Investigation, in m	opinion, d	death occured at the	time, data and	place, and due	to the cause(s) and manner as stated.	
TO THE HOSP! TO THE FUNER De filed within IMPORTANT:	O BE	296. SIGNATURE AND TITLE OF	CERTIFIER	alle 1	ms	A		29c. LICENSE NUN	70		HOV	(Month, Day, Year) 30 [1994]	
	OT.	ALAGONSO VI	ERSON WHO	COMPLETED CAUSE OF	OF DEATH (ITE	EM 27) (Type, Print)	1010	DR, L	116	O MI	30	772	
W		31. DATE FILED (Month, Day, Yea	199/	32. REGISTRAR'S	SIGNATURE	Mandall							
		/		0								DHMH-16 Rev 1/89	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

REG. NO.

FOR STATE REGISTRAR

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		1. DECEDENT'S NAME (First, Middle, Last) FAITH K. NORMAY										
		4. SOCIAL SECURITY NUMBER		B. AGE (In yrs. les	MO	UNDER 1 YEAR		7. DATE OF (Month, D				
모		577-44-8823	1 🗆 M 2 戻 F	60	YRS.		THOUSE WIN.	July	12, 193	4		
3 should	"	90. FACILITY NAME (If not institution, give a		770	96	. CITY, TOWN	OR LOCATION OF D	EATH	9c.	cou		
2,	💆	30. Mr. HOX	CENT	the		Cli	nton		Pr	ir		
- S	ည 	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	γ		10c. CITY. To	OWN OR LOC	ATION			=		
physician. burial-transit permit. Pages 1,	DIRECTOR		e George'	s		restvi						
med.	ERAL	10e. STREET AND NUMBER					IOF. ZIP CODE		1.00	. CIT		
an. ransi	買	6425 Hilmar Drive	: #203				20747		U	Ini		
	BY FUN	11. MARITAL STATUS 1										
r attending use as the	요	15. DECEDENT'S EDU (Specify only highest grade			CEDENT'S US			16b. KI	ND OF BUSINES:	S/IN		
5 5	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life	ive kind of work Do NOT use re	done during i Nired.)	nost of working					
ospitz thed	릴	12		P	hysica	1 The	rapeutist	Gov	gernmen	t		
the hospital detached to once.	0	17. FATHER'S NAME (First, Middle, Last)					ts. MOTHER'S NA					
\$ å ₹	ш	George Washing	ton				Martha	Harri	Lson			
5 should notified	TO B	19e. INFORMANT'S NAME (Type/Print)		19	. MAILING AD	ORESS (Stree	t end Number or Rural	Route Number,	City or Town, Stat	te, Zi		
be rel		Karlton Eric Nor	man	20	Woods Pl	Place, #21, Whea						
> 2 -		20e. METNOD OF DISPOSITION 1 ☑ Burlal 2 ☐ Cremation 3 ☐ Rem	out from State		NDDATEOFD		Name of	OATE	20c. LOCATIO	N —		
rector, present		4 Donetion 5 Other (Specify)	July		ny Mem		Park 12	/1/94	Lando	V		
death. Page (funeral direc i.		21. SIGNATURE OF UNERAL SERVICE LIC	ENSEE	1			AND ADORESS OF FA					
death. funeral		Make 7 8	townset	TIT	'		ART FUNER					
		PART I. Enter the diseasea, or	complications that	caused the de	eth Do not	4001	Benning l	Road,	N. E.,	Wa		
3 - 2		ehock, or heart fellure.	List only one ceus	a on each ilne		onter the n	lode or dying, auc	an all cardiac	or respirator	y ar		
Du, all		iMMEDIATE CAUSE (Final disease or condition	MARRI	15 110	0120 0	.7	4.24.20.6	11				
completely fille ial, cremation,		resulting in death)	a. MASAV	OR AS A CONSE	CIC ()	12.1	PERCUUSIO	746				
B 6 4 5		_	AUTE	RIE	727) /1/	6 46	CAX					
be executivistician and crior to buristication to buristication to buristication traumatic	CERTIFICATION	Sequentially list conditions,		OR AS A CONSE		-) -						
	AT	if any, leading to immediate cause. Enter UNDERLYING	· CHLONI(RIN	4 F	AILVI	re					
ertificati ing phys giene p	F	CAUSE (Disease or injury that initiated events		R AS A CONSE						_		
Jeath certif attending intal Hygier	E	resulting in death) LAST	4									
ne death certificate be the attending physicial Mental Hygiene prior Ijury, or other trau			0.									
= 0 =	EDICAL	PART ii. Other eignificent condition	a contributing to d	eath but not r	eeuiting in t	he underly	ng ceuse given in	Part i. 24	a. WAS AN AUTO PERFORMED?			
	음	THUMACIC ANXT						1	YES 2 N			
quires n sign f Heal	ME	SEVENU PERIPA	unac VA	HC (1)/	EASE							
has been be Dept. of a 23 sho	ä	DID TOBACCO USE	CONTRIBUTE	TO CAU	SE OF D	EATH	YES NO	77				
cate has State De	CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					PLACE OF DEATH (Ch	eck only one)				
certificate the State the State	S	1 TES 2 NO	HOSPITAL: 1 ☑ Inpatient 2 □ E	ER/Outpatient 3		THER: Nursing Ho	me 5 🗆 Residence	6 Other (S	pecify)			
PHYSICIAN: The certificate h	PHY	27. MANNER OF OEATN	28e. DATE OF IN (Month, Day.		28b. TIME OF	F 28c. II	NJURY AT	26d. DESCR	BE NOW INJURY	Y OC		
	ВУ	1 Natural 5 Pending 2 Accident Investigation	(month, bu).	, roury	INSON		YES 2 NO					
8 4 4 4		3 Suicide 8 Could not be	28a. PLACE OF I	INJURY — At ho	me, tarm, atree	et, lactory, of	lce		ON (Street and Nu	ımbe		
OR ATTENDING DIRECTOR: Ahar hours after dead tern 28 is ma	TED	4 Homicide determined	wanang, w	(woody)				Ony or h	own, State)			
P P P P P P P P P P P P P P P P P P P	PLE	29e. CERTIFIER 1 CERTIFYING PNYSI	CIAN: To the best of m	ry knowledge, de	ath occurred s	t the lime, de	te end place, and due	to the causer	e) end manner =	g ste		
HOSPITAL FUNERAL WITHIN 72 TANT: II	- S	one) 2 MEDICAL EXAMINE										
	8	29h SIGNATURE AND TITLE OF CERTIFIE					-					
P 2 2 2 2	BE	Dengount		den h	M		29c. LICENSE NUI	O C	29d.	DAT		

0. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE Fundale

BENJAMIN H. FINDER MAS

31. DATE FILED (Month, Day, Year)
NOV 3 0 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

> 3. TIME OF DEATH 12:22P 8. BIRTHPLACE (State or Foreig Country) 1934 Washington, 9c. COUNTY OF DEATN Prince George's 10d. INSIDE CITY LIMITS? 1 K YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? United States 14. RACE — American Indian, Black, White, etc. Specify **Black** F BUSINESS/INDUSTRY r Town, State, Zip Code) , Wheaton, MD. 20902 c. LOCATION - City or Town, State Landover, Maryland E., Washington, D. reepiratory arreat, Approximate intervei Between Onset and Death 24Hm Uffer 24b. WERE AUTOPSY FINDINGS AMARABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO NA IOW INJURY OCCURED reet end Number or Rural Route Number, State) manner as stated. a, and due to the cause(s) end menner ee stated. 29d. DATE SIGNED (Month, Day, Year) 25/99

> > DNMH-16 Rev 1/89

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AECORDS, P.O. BOX 80760	AL OR ATTENDING DAYSICIAN. The law remides that the death certificate he executed with
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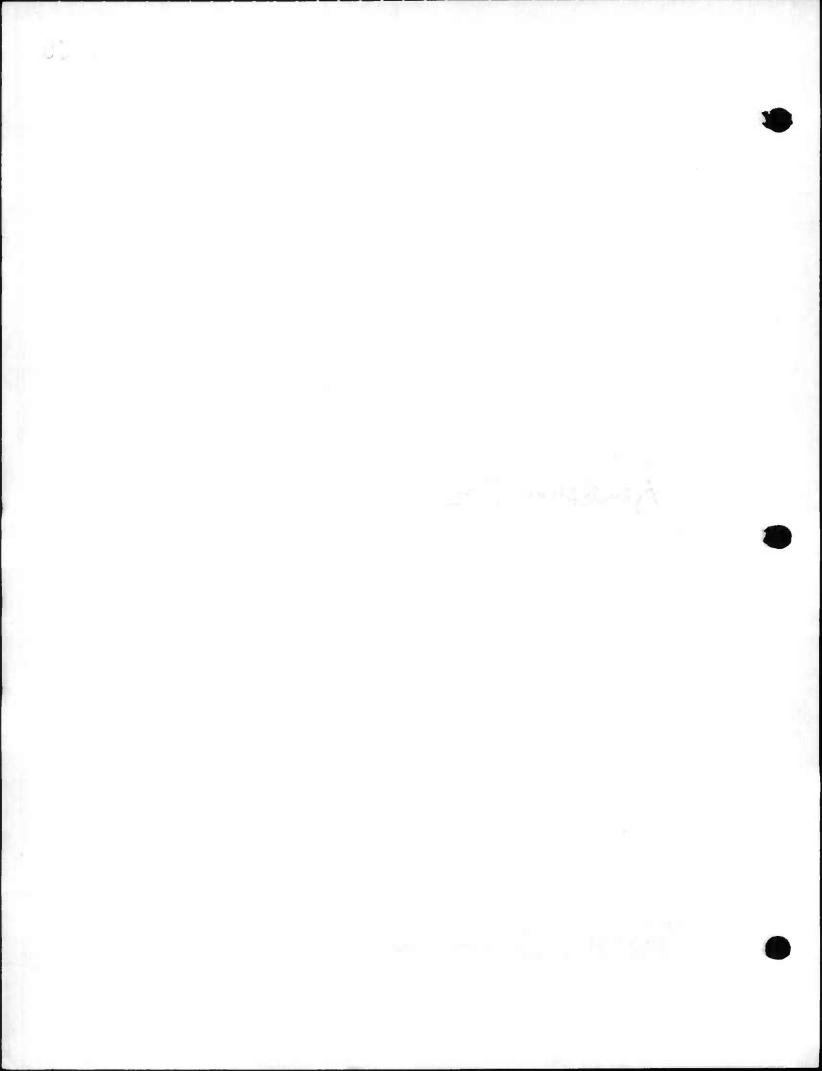
ID THE HIGSPTAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Thours after death. Page 6 may be retained by the hospital or attending physician.	10 THE H. RERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be the complete of the page 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.	MEDITION: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
1	1	-

					94	3/054			
	1 - STATE OF M		TMENT OF HEALTH AND ICATE OF DEATH	MENTAL HYGIEN REG. NO.	_				
	1. OECEDENT'S NAME (First, Middle, Last) AMOUNT A	Nazaren	0	2. DATE OF DEATH ON ON THE PROPERTY OF THE PRO	24,19	3. TIME OF BEATH A M M			
	577-08-4878 1XXM 2 🗆 F	6. AGE (hr/yrs. last birthday) 67 YRS.	IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) 1-19-27	P	BURTHPLACE (State or Foreign Country) hilippines			
TOR	98. FACILITY NAME (If not institution, give street and number) Fort Washington Medical Centerior of December 1	enter	Fort Washingt		9c. COUNTY Prin	ce George's			
BY FUNERAL DIRECTOR	Maryland Prince George		Fort Washingto	n		10d. INSIDE CITY LIMITS? 1 YES 2 NO			
RAL	10e. STREET AND NUMBER		101. ZIP CODE		10g. CITIZEN	N OF WHAT COUNTRY?			
N	3615 Chandler Drive	EVER IN U.S. ARMEO	20744			USA			
		YES 2 X NO	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 NO Speci	an, Puerto Rican, stc.)	or No- 14	RACE — American Indian, Black, White, atc. Specify: Filipino			
COMPLETED	15. OECEDENT'S EOUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of v	USUAL OCCUPATION vork done during most of working e retired.)	16b. KIND OF BUS	SINESS/INDUS				
MPL	7th	Car	penter	Co	onstru	ction			
BE CO	17. FATHER'S NAME (First, Middle, Lest) Esteban Nazare	eno	18. MOTNER'S N	AME (First, Middle, Maiden Salvadora		an			
2	190. INFORMANT'S NAME (Type/Print) Rosalina C. Nazareno		ADDRESS (Street and Number or Rural						
	20a. METNOD OF DISPOSITION	20b. PLACE AND DATE O	Chandler Dr. Ft		LOCATION — City or Town, State				
	1 Burlei 2 Cremation 3 XX Ramovel from State 4 Donation 8 Other (Specify)	cemetery, cremetory or of Nazarene		-28-94 Nai	Vaic, Cavite Philippines				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	George P. Ka	1 Home						
	23. PART i. Enter the diseases, or complications thet shock, or heart failure. List only one caus iMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO	e on aach line.	attenipelization			Interval Retween			
ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): d.								
PHYSICIAN: MEDICAL C	PART II. Other significant conditions contributing to d	1 Part i. 24a. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS MARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
Σ.	DID TOBACCO USE CONTRIBUTE	TO CAUSE OF	DEATH YES IT NO			1 TES 2 NO			
IAN	25. WAS CASE REFERRED TO MEDICAL	TO CAUGE OF	28. PLACE OF DEATH (C						
YSIC	1 YES 2 NO 1 Inputert 2	ER/Outpatient 3 DOA	OTHER: 4 Nursing Nome 5 Residence	8 Other (Specify)					
H	27. MANNEB OF DEATH 1 Netural 5 Pending 28a. DATE OF I		URY WORK?	28d. DESCRIBE HOW I	NJURY OCCUP	RED			
ED BY	2 Accident Investigation 3 Suicide 28a. PLACE OF	INJURY — At home, farm, a	M 1 YES 2 NO	281. LOCATION (Street City or Town, State)	CATION (Street and Number or Rural Route Number, or Town, State)				
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of r MEDICAL EXAMINER: On the basis of axi								
TO BE C	29b. SIGNATURE AND TITLE OF CENTIFIER JULY 130 AND ADDRESS OF PERSON WHO COMPLETED CAUSE	MO	DATA.	AMER 30	TOU DATE S	IGNED (Month, Day, Year) Wort 24,1994			
	AUGUSTO P. LO dr 1945	U.5009 C	y bunch Op.	Su. Md	207	48			
	NOV 2 8 1994 This Day	idson-Aandell.	· /	V					

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \$4 %ours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

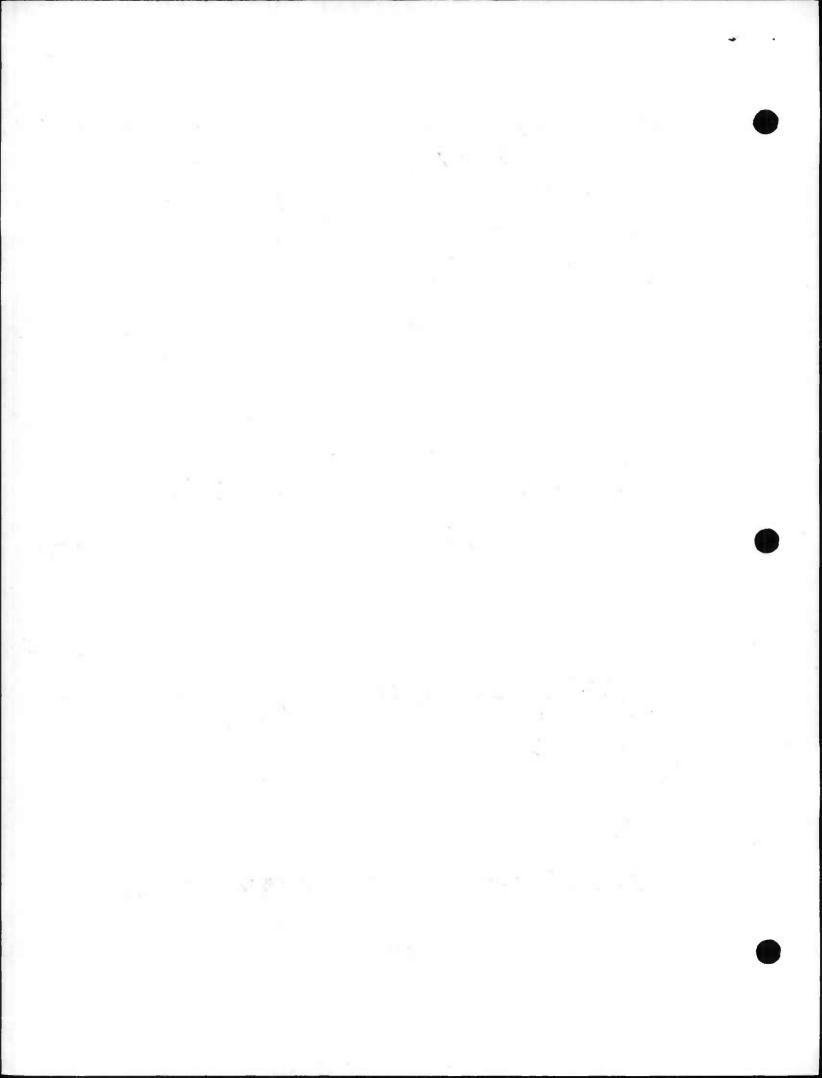
	HEGISTHAH			=KIII	ICALI	= OF	DEA	ГН	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH		1000	3. TIME OF OEATH
	MONTH DAY										YEAR	
						_				, 1994		2:10 A M
	4. SOCIAL SECURITY NUMBER	5. SEX 6	. AGE (In yrs. les	f birthday)	IF UNDER		IF UNDER		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTH Countr	PLACE (State or Foreign
	186-05-6594	1 🔀 M 2 🗆 F	87	YRS.	MONTHS	DAYS	HOURS	MIN.	December 2,	200		yland
	Se. FACILITY NAME (If not institution, give a	treet and number)	07		05 0077	TOMBLE	R LOCATI	011.05.05				
œ	The state of the s	moot and marriage			PB. CITT	, IUWN C	IN LOCALI	ON OF DE	AIH	9c. COU	NTY OF D	EATH
FUNERAL DIRECTOR	308 South Third	Street				Den	ton			Ca	roli	ne
5	RESIDENCE OF DECEDENT											
Ü,	10a. STATE 10b. COUNT	Υ		10c, CIT	Y, TOWH (OR LOCAT	ION	_				10d. INSIDE CITY
<u></u>	Maryland	Caroline				Den	han					LIMITS?
		carorine				Den	COII					1 X YES 2 NO
4	10e. STREET AND NUMBER					101	ZIP COD	E		10g. CIT	IZEN OF V	VHAT COUNTRY?
65	308 South Third :	Street					21	1629		II.	S.A.	
Ž	11. MARITAL STATUS	12. WAS DECEDENT			1.0							
E 1	1 Never Married 2 Nameried	FORCES? 1			13.	WAS DEC	ENDENT C	OF HISPAN	IC ORIGIN? (Specify Yes	or No-	14. RACE	— American Indian, c, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAI				1 YES	2 XNO	Specify	:		Speci	
	3 Widowed 4 Divorced											casian
유	15. DECEDENT'S EDU	CATION	18a. DE	CEDENT'S	USUAL O	CCUPATIO	ON		16b. KIND OF BU	NESS/INI		castan
E	(Specify only highest grade		(G	ive kind of a Do NOT us	vork done	during mo	st of working	ng				
ا ت	Elementary/Secondary (0-12)	College (1-4 or 5+)						_	Superi			
불	8	None	Pro	perty	/ Sup	peri	ntend	dent	Pro	operi	ties	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTI	HER'S NAI	WE (First, Middle, Maiden	Sumame)				
	Tamos M	arion Nei				-	20111	nh Mary 1	6-7			
H		arion Nel						ah May 1				
2	19s. INFORMANT'S NAME (Type/Print)	b, MAILING	ADDRESS	(Street a	nd Number	or Rural F	loute Number, City or Tow	n, State, Zij	Code)			
-	Helen M. Neighbor	308 8	South	Th:	ird S	Stree	et, Denton	. Mar	vlan	d 21629		
- 1	20a. METHOD OF DISPOSITION		20b. PLACE		-			70200			-	
	1 S Burlai 2 Cremation 3 Rem	oval from State	cemetery, cre			ITION /Ne	me of			CATION —	City or To	wn, Stats
	4 Donation Ther (Specify)		Dent	on Ce	emete	ery			11/10 De	entor	, Ma	ryland
- 1	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSES /			22.	NAME AN	D ADDRES	SS OF FAC			•	
_	11/ 11/1	1//1			A	foor	Fur	ora1	Home, P.	1		
_	Kausey	Fr 1 1/0	ne	-	Ι'n)rawe	or R.	Der	ton, Mary	land	2162	a
	23. PART I. Enter the diseases, or o	complications that	eused the de	eth Dor	Ot enter	the me	do of du	no evol	an cording on a cord	- Annua	2102	
	23. PART I. Unter the diseases, or o shock, or heer fellure.	List only one ceuse	on eech line		ot enter	the mo	de or dy	ing, auci	as ceruled or respi	ratory en	est,	Approximata interval Between
	IMMEDIATE CAUSE (Finel						4					Onset and Death
	disease or condition		INCOC	00	-DIA	1	INF	PRC	DON			MINUROS
H	resulting in death)	a.	2000000			-	1		150 ×50			1.1100
	Us Es	OUE TO (O	N AS A CONSEC	DENCE OF	·):		-)			11
Ž.	Sequentially list conditions.	۵	ARL	1	125A	ER y	1	155450			18-412-S.	
ĔΙ	If any, leading to immediate	DUE TO (O	R AS A CONSEC	UENCE OF	ENCE OF							
X I	cause. Enter UNDERLYING				1							
E I	CAUSE (Disease or injury	DUE TO (O	R AS A CONSEC	NIENCE OF	n.							
EI	that initiated events resulting in death) LAST	202.0(0	AO A CONSEC	JOENOE OF	7-							i
CERTIFICATION		d										
	DART !! 00											
EDICAL	PART II. Ofher eignificent condition	s contributing to de	eth but not r	eaulting i	n the un	derlying	ceuse (given in i	Part I. 24s. WAS AN		24b.	WERE AUTOPSY FINDINGS
<u>ੂ</u>	MULTIPLE	RZSVIW	NFR	1205	20N	5			PERFOR		1	AVAILABLE PRIOR TO COMPLETION OF CAUSE
									1 🗆 YES 2	NO		OF DEATH?
												1 TES 2 NO
÷												
PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL					26 DI	ACE OF O	EATH Ch	ck only one)			
2	EXAMINER?	HOSPITAL:			OTHER	-	ACE OF U	EATH (C//e	CK Only one)			
S	1 TYES 2 NO	1 Inpatient 2 E	R/Outpatient 3	□ DOA			5 A	sidence	B Other (Specify)			
Ŧ	27. MANNER OF DEATH	28a. DATE OF IN		26b. TIM		28c. INJ	JRY AT		28d. DESCRIBE HOW II	JURY OC	CURED	
	1 Natural 5 Pending	(Month, Day,	Year)	INJ	URY		RK7 'ES 2	1 10				
B								JNO				
									281. LOCATION (Street e City or Town, State)	nd Number	or Rural R	oute Number,
	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF I	NJURY — At hor :. (Specify)									
	2 Codeldo	28s. PLACE OF I building, ato	Specify)					- 1				
	3 Sulcide 8 Could not be determined	building, at	: (Specify)				-					
	3 Suicide 4 Homicide 8 Could not be determined 29s. CERTIFIER (Check only) 1 CERTIFYING PHYSIC	CIAN: To the best of m	: (Specify)	eth occurre								
	3 Suicide 4 Homicide 8 Could not be determined 29s. CERTIFIER (Check only) 1 CERTIFYING PHYSIC	CIAN: To the best of m	: (Specify)	eth occurre								and manner ea stated,
COMPLETED	3 Suicide 4 Homicide 8 Could not be determined 29a. CERTIFFIER (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of m	: (Specify)	eth occurre			enth occur	ed at the i	ime, data end placa, an			and manner sa stated.
COMPLETED	3 Suicide 4 Homicide 8 Could not be determined 29s. CERTIFIER (Check only) 1 CERTIFYING PHYSIC	CIAN: To the best of m	: (Specify)	eth occurre			enth occur		ime, data end placa, an	d due to th	e ceuse(s)	and manner sa stated. (Month, Dayl Year)
BE COMPLETED	3 Suicide 4 Homicide 8 Could not be determined 29a. CERTIFFIER (Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of m	: (Specify)	eth occurre			enth occur	ed at the i	ime, data end placa, an	d due to th	e ceuse(s)	
COMPLETED	3 Suicide 4 Homicide 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER	CIAN: To the best of m	r knowledge, dei	ath occurre	n, In my o		enth occur	ed at the i	ime, data end placa, an	d due to th	e ceuse(s)	
BE COMPLETED	3 Suicide 4 Homicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF DERTIFIER 30 NAME AND ADDRESS OF PERSON WHI	CIAN: To the best of my	r knowledge, dei	nth occurrent oc	n, le my o	pinion, de	29c. LICE	NSE NUM	ime, data end placa, an	d due to the	E SIGNED	(Month, Devi Year)
BE COMPLETED	3 Suicide 4 Homicide 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIER	CIAN: To the best of my	r knowledge, dei	nth occurrent nveatigation	n, le my o	pinion, de	enth occur	NSE NUM	ime, data end placa, an	d due to the	E SIGNED	(Month, Devi Year)
BE COMPLETED	3 Suicide 4 Homicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF DERTIFIER 30 NAME AND ADDRESS OF PERSON WHI	CIAN: To the best of man. R: On the best of exercises of	of DEATH (IJEN	ath occurrenveatigatio	n, le my o	pinion, de	29c. LICE	NSE NUM	ime, data end placa, an	d due to the	E SIGNED	(Month, Devi Year)
BE COMPLETED	3 Suicide 4 Homicide 8 Could not be determined 299. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF DERTIFIER 30 NAME AND ADDRESS OF PERSON WHI	CIAN: To the best of man. R: On the best of exercises of	y knowledge, de	ath occurrenveatigatio	n, le my o	pinion, de	29c. LICE	NSE NUM	ime, data end placa, an	d due to the	E SIGNED	(Month, Devi Year)



1 - FOR STATE REGISTRAR

		1. DECEDENT'S NAME (First, Middle)	estelle 0	hler				2. DATE OF DE MONTH	TATH DAY	YEAR/	3. TIME OF DEATH
pin		4. sóciál seculity number 219–20–2614	1 🗆 M 2 🗡 F	AGE (In yrs. last	YRS. MO	UNDER 1 YEAR NTHE DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIF (Month, Day, Oct 2	5, 1915	Md.	
1, 2, 3 should	стоя	98. FACILITY NAME (# not institution Frederick Memorial Presidence of December 1987)	orial Hospita	1	96		rederick	ATH	se. coun	ry of oe	
Pages	DIRE	10a. STATE 10b.	Frederick			own or Local					IOd. INSIDE CITY LIMITS?
n. ansit permit.	FUNERAL	4105 Cherry La	ane	2.41		101	7. ZIP COOE 217	755		S.A.	IAT COUNTRY?
215-0020 attending physician. se as the burlat-transit	BY	11. MARITAL STATUS 1 Never Married 2 Marrie 3 Wildowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	YES 2 N		If yes, sp	ENDENT OF HISPAN ecity Cuben, Maxica 2 NO Specify	n, Puarto Rican,	city Yes or No—	Black, Specify	- American Indian, White, stc. Thite
5 2	PLETED		T'S EDUCATION est grade completed) College (1-4 or 5+)	(Gi	ve kind of work Do NOT use re	JAL OCCUPATION done during modified.)	ON ost of working	16b. KIND	OF BUSINESS/INDU		
d by the hospital of be detached for at once.	1 1	17. FATHER'S NAME (First, Middle, Franklin C	lifford Hoffma	an	TIOMA	AMARICE	18. MOTHER'S NAI				
ay be retained page 5 should be notified	2	Beverly L. Oh	*		105 CI	nerry 1	Lane, Jef	ferson	, Md. 21	L755	
e 6 m ector,		20a. METHOD OF DISPOSITION 12 Burlet 2 Cremetion 3 4 Donation 5 Other (Spec	(v)	cometery, crer	matory or other.	<u>lemeter</u>		12/6	iddletov		
SALI r death. he funera al. examil		Mylld 5	Showson			Donal 31 E	ld B. Tho Main St	ompson l	lletown,	Md.	21769
with the pletely filler cremation, rent, the		23. PART I. Enter the disease shock, or heart I IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a	aused the de on each lina.		antar tha mo	da of dying, such	n se cardiac o	r reaptratory erre	st,	Approximata interval Between Onset and Death
ificate be executed the physician and come prior to burial, the traumatic events are traumatic events.	FICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	c	R AS A CONSEC							
the death cert the attending of Mental Hygin injury, or of	5	resulting in death) LAST	d								1
equires that the en signed by the of Health and N. hows any inj	2	PART II. Other significant co	fine + /	pates	Seaulting in the	ha underlying	g cauaa givan in	Part I. 24a. \ I	NAS AN AUTOPSY PERFORMEO? YES 2 NO	0	VERE AUTOPSY FINDINGS WALLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES NO
	Z	DID TOBACCO 25. WAS CASE REFERRED TO MED EXAMINER?	USE CONTRIBUTE	TO CAU		26. PL	YES NO				/
OR ATTENDING PHYSICIAN: The law DIRECTOR: After this certificate has thours after death with the State Dept Item 28 is marked, or Item 23	PHYSI	1 VES 2 NO 27. MANNER OF DEATH Natural 5 Pendii	28a. DATE OF INJ	JURY		28c. INJ	URY AT PRK?		HOW INJURY OCCU	JRED	
	TED BY		getion 28a. PLACE OF III building, atc.	NJURY — At hor . (Specify)	ne, ferm, stree		YES 2 NO	28f. LOCATION City or Town	(Street and Number of, State)	r Rural Ro	ute Number,
TAL OR TAL DIRI	COMPLET		G PHYSICIAN: To the best of my								and manner as stated
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If	띪	29b. SIGNATURE AND TITLE OF CO		m	mo		29c. LICENSE NUM 7 -/39				Month, Day, Year)
	0	30. NAME AND ADDRESS OF PERS								1-1	
		31. DATE FILEO (Month, Day, Year) DEC 07	1994 32. REGISTRAR'S	SIGNATURE TRUCKS	Rarball						

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



ITEMS: 23 PART I, 27, PER MEO FILM G-719 1/23/95 t.t

FOR
STATE
STATE
STATE
STATE
STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CERTIF	ICATE (OF DEATH	REG. NO.			
		DECEDENT'S NAME (First, Middle, Lest) KWAKU	(NMN)		OKYERE		2. date of OEATH November 2	2, 1994	EAR 3.	3:04 P.
2		4. SOCIAL SECURITY NUMBER N/A	1 🔀 M 2 🗆 F	(In yrs. last birthday) 48 YRS.	IF UNDER 1 YE		7. OATE OF BIRTH (Month, Day, Year) July 31,		Country)	CE (State or Foreign Ghana
3 should	<u>د</u>	9a. FACILITY NAME (If not institution, give st Holy Cross Hospit				wn or Location of Di er Spring	EATH	9c. COUNTY		
1. 2,	ЕСТОВ	RESIDENCE OF DECEDENT			DIIV	of Opting		rione	gome	L y
permit. Pages 1	DIREC	Maryland 106. COUNTY	Montgomery		ry, town on L Silver	Spring				d. INSIDE CITY VLIMITS? YES 2 NO
permit	ERAL	10e. STREET AND NUMBER	11 - 0 - 1			101. ZIP CODE	· ·	10g. CITIZEN		T COUNTRY?
ransi	삘	12002 Swallow Fa				20904			Ghan	a
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit notified at once.	BY FUN	11. MARITAL STATUS 1 Never Married 2 K Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 XNO	If yes	DECENDENT OF HISPAN , specify Cuban, Maxica YES 2 XNO Specify		or No — 14.	RACE — Black, W Specify:	American Indian, hita, atc. Black
r attend	입	15. OECEDENT'S EDUC (Specify only highest grade	CATION	16a. DECEDENT'S	USUAL OCCU	ATION	16b. KIND OF BUS	SINESS/INDUST	TRY	
D 21 spital or ned for u	COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	IIIe. Do NOT u	employe	most of working	Gold i	Mining		
AND he hospit detached once.	0	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)		
MARYL, retained by th 5 should be d	BE C	Baffour Okyere					akyiaw			
MAR retained 5 should notified		19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Str	eet and Number or Rural i	Route Number, City or Tow	n, State, Zip Coo	_(a) 20	904
be rett ge 5 s	2	Austin Appaih		12002	Swal:	low Court	Silver Sp	ring,M	aryl	and
MORE, age 6 may be director, page		20s. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Ramo 4 Donation 5 Other (Specify)	oval from Stata Cec	PLACEAND DATE metery, cremetory or t Kumasi C	other plece)		2/10/94Kum	cation - city		State
Page al dire	0	21. SIGNATURE OF FUNERAL SERVICE LIC		TOLINGO I	22. NAM	E AND ADDRESS OF FA	CILITY			
BALIIMORE, after death. Page 6 may be y the funeral director, page noval. cal examiner must be in	Ц	· 485.	hi-				Funeral H ilver Spri			
ely filled in tenation, or red		23. PART i. Entar the diseases, or cahock, or haart failure. I iMMEDIATE CAUSE (Final disease or condition resulting in death)	List only one cause on a	ach lina.	BY SUB/			ratory srrest	,	Approximate Interval Between Onset and Death
and and bur matic	NOI	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE O	PF):					
ficate be physician the prior to	-ICA	CAUSE (Disease or injury	DIJE TO (OP AS	A CONSEQUENCE O	· D.					
ending Hygie	CERTIFICATION	that initiated events resulting in death) LAST	s	CONSEQUENCE	·r);					
Senta de at		PART II. Other algnificant conditions	e contributing to death i	nut not consisten	In the conden	dan samuel et e	nest Income			
that the death ned by the attentith and Mental I any Injury, o	MEDICAL	The state of the s	- Contributing to death t		- Inthe under	ying cause given in	Part I. 24a. WAS AN PERFOR	MED?	AMI	RE AUTOPSY FINDINGS ALABLE PRIOR TO MPLETION OF CAUSE DEATH?
taw requires that as been signed the Dept. of Health at 23 shows any							_ ′		1	YES 2 NO
has be Dept.	N.	DID TOBACCO USE CONTR	RIBUTE TO CAUSE C				1 🗆			
en ate h	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1X YES 2 NO	HOSPITAL:	26. PLACE OF DEA	OTHER:		a 🗆 au 🗀 au 🗀			
Sicial Sicial Certification of the certification of	PHYS	27. MANNER OF OEATH	26a. OATE OF INJURY	28b, TIN	E OF 28c	Home 5 Realdence	6 U Other (Specify) 28d. DESCRIBE HOW II	NJURY OCCUR	ED	
DING PHYS After this death with	ВУ Р	1 XX Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)			WORK? YES 2 NO				
28 Lafter	ETED	3 Suicide 8 Could not be 4 Homicide detarmined	28a. PLACE OF INJURY building, atc. (Spe-	cify)	streef, factory,	offica	261. LOCATION (Street a City or Town, State)	ind Number or F	Rural Floute	Number,
	COMPLI		CIAN: To the best of my know R: On the basis of examination						iuse(a) an	d manner as stated.
TO THE HOSPI TO THE FUNE! De filed within	BE	29b. SIGNATURE AND TIPLE OF CERTIFIER	Mell	_		O. C.M.				onth, Day, Year) 9-94
	5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE			reet. Bal	timore, Ma			
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	IATURE .				J =====		
		NUV 3 0 1994	4 Julia David	son-Randal	2					

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DIVISION OF VITAL RECOF

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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TO BE COMPLETED BY FUNERAL DIRECTOR

FOR 1 - STATE REGISTRAR	STATE OF MARYLA	AND / DEPART	TMENT OF	HEALTH AND	MENTA	L HYGIEN	E			
1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH		3.	. TIME OF DEAT	ГН
Thomas David Otto					Nove	mber 2		PAR	7:10	Рм
		n yrs. last birthdey)	IF UNDER 1 YEAR	IF UNDER 24 HRS.		OF BIRTH		BIRTHPL Country)	ACE (State or Fo	oreign
220-38-2986 1 9a. FACILITY NAME (If not institution, give street		2 YRS.		2350 30	Apri	1 4,19		?enns	sylvani	la
1				OR LOCATION OF D	DEATH		9c. COUNT	Y OF DEA	ТН	
8436 Towne Crest (Jourt		Gaith	ersburg			Mo	ntgo	nery	
10s. STATE 10b. COUNTY		10c. CITY	TOWN OR LOCA	TION			-	10	Dd. INSIDE CITY	,
	gomery	Ga	aithersl	ourg				1	YES 2	NO
10e. STREET AND NUMBER			10	1. ZIP CODE			10g. CITIZE	N OF WHA	AT COUNTRY?	
8436 Towne Crest C				20877	7			U.	S.A.	
11. MARITAL STATUS 12 1 Never Married 2 X Married	2. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DE	CENDENT OF HISPA	NIC ORIGI	N? (Specify Yes	or No- 14	RACE -	American India Vhita, atc.	an,
3 Widowed 4 Divorced	IF YES, GIVE WAR OR OA	TESA		2 NO Specif		, , , , , , ,		Specify:		
15. DECEDENT'S EDUCATI	ION	16a. DECEDENT'S I	USUAL OCCUPATI	ON	161	. KIND OF BUS		hite	е	
(Specify only highest grade con Elementary/Secondary (0-12)	npleted) College (1-4 or 5+)	(Give kind of we life. Do NOT use	ork done during m retired.)	ost of working	"					
12		Letter (Carrier			Posta1	. Serv	ice		
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First,	Middle, Maiden	Surname)			
	Otto			Betty	у		O Doni	nell		
19a. INFORMANT'S NAME (Type/Print)		1		and Number or Rural		ber, City or Tow	n, State, Zip Co	ode)	2087	77
Mary L. Otto		8436 1	Cowne Ci	est Cour	rt G	aither	sburg	Mary	yland	
20a, METHOD OF DISPOSITION 1 (A Burlal 2 Cremation 3 Removal	from State 1 come	PLACE AND DATE O	ner nlace)				CATION — CIT			
4 □ Donation 5 □ Other (Specify)	Pa	rklawn (Cemetery	11/	/30/9	4 Rock	ville	Maı	ryland	
21. SIGNATURE OF PUNERAL SERVICE LICENS) ()		Franci	ND ADDRESS OF FA	ACILITY Llins	Funer	al Hor	ne.	Inc.	
Apriles & b	Joseph		500 Ur	iversity	y Blv	d.,W.	Sil.Si	or.,l)1
23. PART i. Inter the diseases, or com ahock, or heart feliure. List	plications that caused	the death. Do no	ot entar tha me	ods of dying, suc	ch as csr	diac or reapi	ratory arres	t,	Approxima	sta
IMMEDIATE CAUSE (Final	t cause on as	on ima.							Interval Bo	
disesse or condition resulting in death)	DUE TO OR AS A	ancer							IYR	
	DUE TO OR AS A	CONSEQUENCE OF):						1310	
Sequentially list conditions, b.	Ban-	META	BIAGE	>					1111	
if any, issding to immediate cause. Enter UNDERLYING	ODE TO (OR AS A	CONSEQUENCE OF	i.						i	
CAUSE (Disesse or Injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):						1	
resulting in death) LAST									!	
DADY II Other significant and like										
PART II. Other aignificant conditions of	ontributing to death bu	it not resulting in	ths underlyin	g cause givan in	Part I.	24a. WAS AN PERFOR		AV	ERE AUTOPSY FI WILABLE PRIOR	TO
						1 TYES 2	NO		OMPLETION OF C F DEATH?	AUSE
								1.	YES 2 1	10
DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL				UNCERTAI	ИП					
EXAMINER? H	OSPITAL:		OTHER:							
1 TYES 2 NO 1	Inpatient 2 ER/Outpa	28b, TIME		ne 5 Rasidenca	7					
Natural 5 Pending	(Month, Day, Year)	INJU	IRY WO	FURY AT DRK? YES 2 NO	284. UE	SCRIBE HOW II	NJURY OCCUI	RED		
2 Accident Investigation 3 Suicide	28a. PLACE OF INJURY	— At home, farm, at			284 1 00	ATION (Street a	and Mumber or	Dural Basel	to Month or	
4 Homicide 6 Could not be	building, atc. (Specif	(y)	Total Marioty, Office	•	City	or Town, State)	ind Number of	norar nous	e Number,	
29a. CERTIFIER Check only	N: To the heat of my transfer	don don't see	d at the time of the	and place			-			-
	On the basis of examination								nd manner en -	
290. SUMATURE AND TITLE OF CERTIFIER						prece, en				
CANKIN				29c. LICENSE NUI	MBER	-	29d. DATE S	GNED (M	Onth, Day, Year)	_
30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETEO CAUSE OF OFA	TH (ITEM 27) /Tope 1	Print)	N >> 6	577		- (1	127	77	-
Dr. Kenneth Miller	18111 Prin	ce Phili	p Drive	Olney M	ID 20	832		- '		
31. DATE FILEO (Month, Day, Year)	32 REGISTRAR'S SIGNA	TURE								

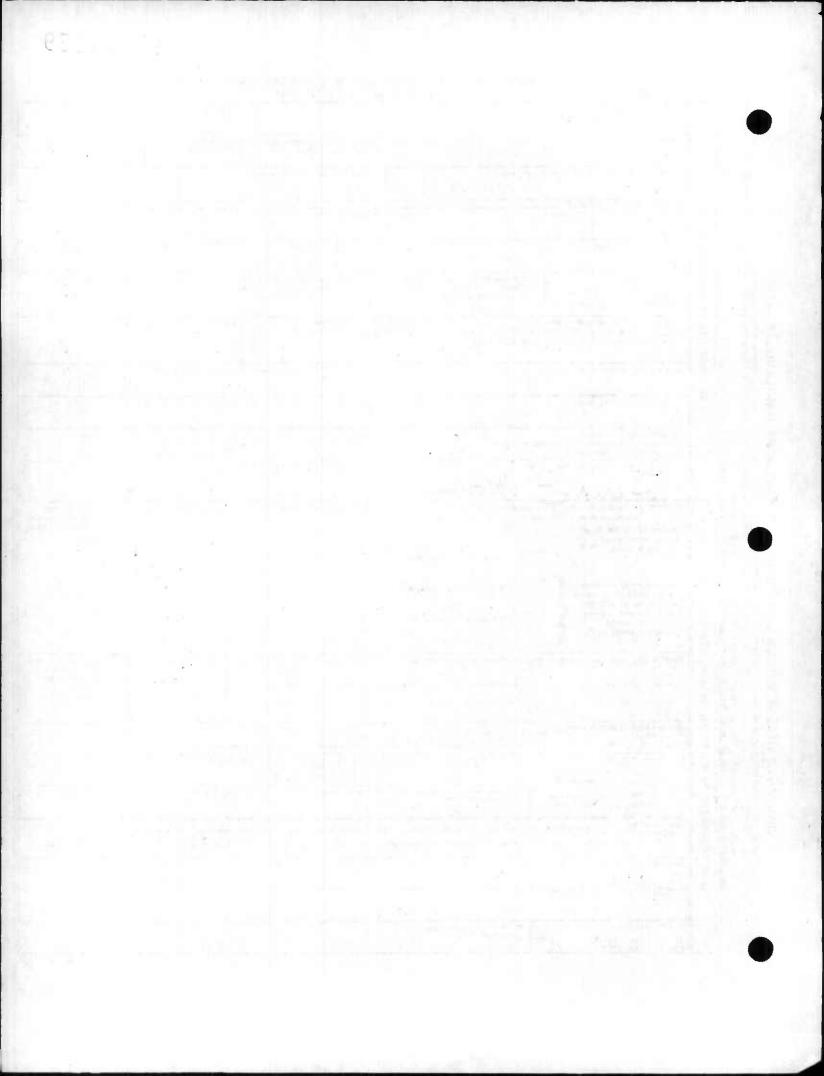


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2		98. FACILITY NAME (If not institution, give	street end number)		9b. CITY, TOV
3 \$40	S.	PHYSICIANS MEM	ORIAL HOSE	PITAL	LAPLA
1, 2,	DIRECTOR	RESIDENCE OF DECEDENT			12
30es	2	10e. STATE 10b. COUNT	Υ	10c, C	ITY, TOWN OR LO
<u>a.</u>	1	Maryland Char	les	Wa	ldorf
E 96	A	10e. STREET AND NUMBER			
. USit	8	245 Berry Road			F 1.7
ocidan al-tra	FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER		13. WAS
D20		1 Never Married 2 X Merried	FORCES? 1 YES		If yes
9 19 19	BY	3 Widowed 4 Divorced	II TES, GIVE TEST ON	DATES	
BALTIMORE, MARYLAND 21215-0020 or death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the burial-transit permit. Pages wal.	0	15. DECEDENT'S EDU		16a. DECEDENT	'S USUAL OCCUP
212 o o so so	H	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind o	f work done during use retired.)
S Site	7	9th	College (1-4 of 5 +)	Homem	aker
AN the hos detach	COMPLETED	17. FATHER'S NAME (First, Middle, Last)		1101110111	
1 de de de de de de de de de de de de de		John P. Connol	1		
MARYL retained by 5 should be	BE	190. INFORMANT'S NAME (Type/Print)	. 1 y		
MAR retained 5 should	2	The state of the s		245	Berry
y be y		Diane Owens		Wald	orf.
BALTIMORE, after death. Page 6 may be the funeral director, page moval.		20e. METHOD OF DISPOSITION 1 X Burial 2 Cremetion 3 Rem		b. PLACE AND DATE	
ALTIMOR death. Page 6 ma s funeral director, p 1.		4 Donation 5 Other (Specify)	IC	edar Hi	
TTIPE IN STREET		21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		Mars
AL fune fune xam		Nank >	ALITM		4308
B, after rs after by the removal		23. PART I. Enter the diseases, or	, X) ou	445 4 4 5	
in the		shock, Dr heart fellure.	List only one cause on	aech line.	not antar tha
y filled i		IMMEDIATE CAUSE (Finel			
tely mattic		disease or condition resulting in death)	. Respira	tory Ar	rest
P.O. BOX 68760, the certificate be executed with ending physician and completely filled thygiene prior to burial, cremation, or other traumatic event, the			e. Respira	A CONSEQUENCE	OF):
curted d col urial,	z		h Pulmono	rv Fibr	ooi o
X 6	은	Sequenticity list conditions, if any, leading to immediate	b. Pulmona:	A CONSEQUENCE	0515 0F):
certificate be extending physician a Hygiene prior to by or other trauma	18	cause. Enter UNDERLYING	. Aspirat:	ion Dno	umonie
iffical phy	Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OR AS	A CONSEQUENCE	OF):
O. O. D.	CERTIFICATION	resulting in death) LAST			
OF VITAL RECORDS, P.O. BOX 68760, PHYSICIAN: The law requires that the death certificate be executed with this certificate has been signed by the attending physician and compet with the State Dept. of Health and Mental Hyghere prior to burial, corrected, or litera 23 shows any injury, or other traumatic event	S		0.		
the deat the deat by the atte	4	PART II. Other algnificant condition	na contributing to death	but not reaulting	in the underl
ORC that the ned by the tith and	PHYSICIAN: MEDICAL				
AL RECO					
Sheen Sheen	2				
AL F e law r has be Dept.	NA N	25. WAS CASE REFERRED TO MEDICAL			20
F VITA SICIAN: The certificate h the State 1, or Item	2	EXAMINER?	HOSPITAL:		OTHER:
CIAN CIAN the Street	Ι×S	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Ou		4 Nursing
OF PHYSIC this ce with t	급	tx Natural 5 Pending	(Month, Day, Year)		IME OF 28c.
	B	2 Accident Investigation			M 1
Non de la la la la la la la la la la la la la		3 Suicide 8 Could not be	28e. PLACE OF INJUR building, atc. (Sp.	(Y — At home, farm ecify)	, atreet, fectory,
ATTE ATTE STOOM	12	4 Homicide determined			
DIVISION THE HOSPITAL OR ATTENDING THE FUNERAL DIRECTOR: After flied within 72 hours after death PORTANT: If Item 28 is mail	COMPLETED	290. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my kno	wledge, death new	rred at the time
Z 4 € =	M	onel	ER: On the basie of examinati		
HOSF UNE Vithin	8			and an investigation	
TO THE HOSPITAL TO THE FUNEPAL (De filed within 72 h	BE	296. SIGNATURE AND TITLE OF CERTIFIE	R. 1 11		
5 5 9 M	0	muly.	lever		
	-	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE OF D	EATH (ITEM 27) (Typ	oe, Print)

U 2 1994

1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH N MONTH 29 DAT 994 YEAR 3. TIME OF DEATH MARY ELIZABETH OWENS 11:30PM M 7. DATE OF BIRTH (Month, Dey, Year) 0. BIRTHPLACE (State or Foreign Country) Washington, DC 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 F 215-64-6013 39 YRS. WN OR LOCATION OF DEATH 9c. COUNTY OF DEATH TA CHARLES CATION 10d. INSIDE CITY 1 K YES 2 NO 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20603 USA DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. YES 2 K NO Specify Specify: White PATION g most of working 16b. KIND OF BUSINESS/INDUSTRY Self. 16. MOTHER'S NAME (First, Middle, Malden Surname) Catherine Sullivan er and Number or Rural Route Number, City or Town, State, Zip Code) MD 20603 20c. LOCATION - City or Town, State N /Name of DATE Suitland, MD netery shall's Funeral Home, Inc. 8 Suitland Rd. Suitland, MD 20746 mode of dying, such as cerdiac or respiratory arrest, Approximata Onset and Death 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY PERFORMED? ying cause given in Part I. 1 TYES 2 NO 1 TYES 2 NO 6. PLACE OF DEATH (Check only one) Home 5 - Residence 8 - Other (Specify) INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED YES 2 NO office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) date end place, and due to the cause(e) end menner as stated. n, death occured at the time, date and place, end due to the cause(s) and menner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D-21031 /30/94 WALDORF, MD MICHAEL LEATHERWOOD M.D. WALDORF MEDICAL PARK P.O. BOX 20604 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE



DIVISION OF VITAL RECORDS, P.O. BOX 68760

ained by the hospital or attending physician.	stely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3		fled at once.
death certificate be executed with. Hours after death. Page 6 may be retained by the hospital or attending physic	ined by the attending physician and completely filled in by the funeral director, page 5.	ne prior to burial, cre	iry, or other traumatic event, the medical examiner must be notified at once
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certifing	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the	be filed within 72 hours after death with the State Dept, of Health and Me	MPORTANT: If item 28 is marked, or item 23 shows any injury, or oth

DIRECTOR

FUNERAL

BY

COMPLETED

BE

2

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

2

that initiated events

25. WAS CASE REFERRED TO MEDICAL

5 Pending

Investigation

1994 9

6 Could not be determined

1 YES 2 NO

31. DATE FILED (Month Day Year

27. MANNER OF DEATH

1 Natural
2 Accident

3 Sulcide

4 Homicide

94 37060 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY 04 12 Edith Pollen Ann det. 2:07 4. SOCIAL SECURITY NUMBER 6 SEY July 20 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 577-32-0595 89 1 M 2 X F 9a. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Meridian Nursing Home Frederick Frederick RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Carroll County Kevmar 1 YES 2 NO 10a, STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 12505 Renner Road 21757 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, Whita, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES ZYONO Specify: Specify: 3 W Widowed 4 Divorced white 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only his Elementary/Secondary (0-12) College (1-4 or 5+) Housewife 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname) Ernest Kidwell Katie Hart 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emily Cregger Renner Rd. Keymar, Md. 21757 20a. METHOD OF DISPOSITION
1 ☆Burlal 2 ☐ Cremetion 3 ☐ Removal from Stata 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE Linden Hills 4 Donation 8 Other (Specify) Frederick, 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hilton Funeral Home Barnesville, Md. 20838 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory errest, Approximate shock, or heart feiture. List only one cause on each line intervai Between **IMMEDIATE CAUSE (Fine)** Onset and Death disesse or condition resulting in desth) Comu on ex DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury

resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i.

DUE TO (OR AS A CONSEQUENCE OF):

1 Inpatient 2 ER/Outpatient 3 DOA

24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 - YES 2 NO

1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 26. PLACE OF DEATH (Check only one)

OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED

28e. DATE OF INJURY (Month, Dev. Year) 26b. TIME OF INJURY t YES 2 NO 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Soecify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER

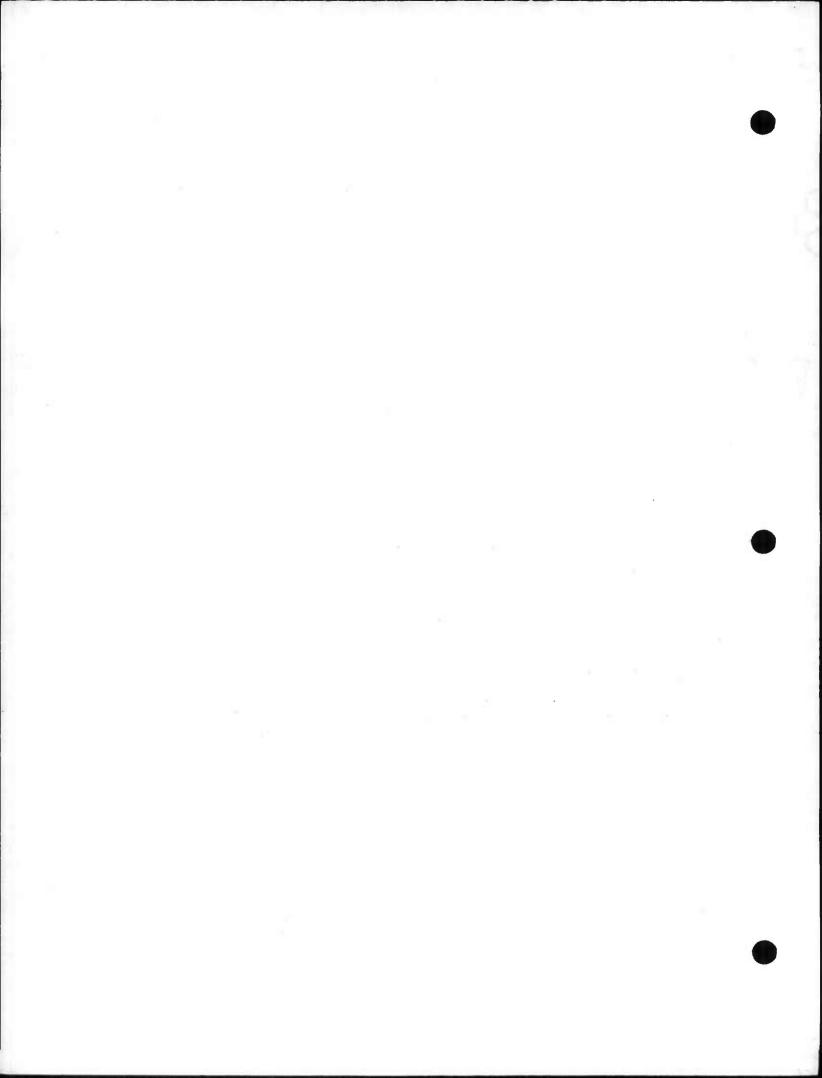
Chart and CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated.

2	MEDICAL EXAMINER: On	the basis of axamination	n and/or investigation,	in my opinion, de	ath occured at the time,	data and place, and	dua to the cause(s)	and manner as stated
-	- 1	d-						

96. SIGNATUBE AND IT BE OF CERTIFIER 29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PER COMPLETED CAUSE OF DEATH (ITEM 27) (Typg, Print) -(C)

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32. REGIS			LOC	and the	7



Pages 1, 2, 3 should

Dr. Zafar Malik

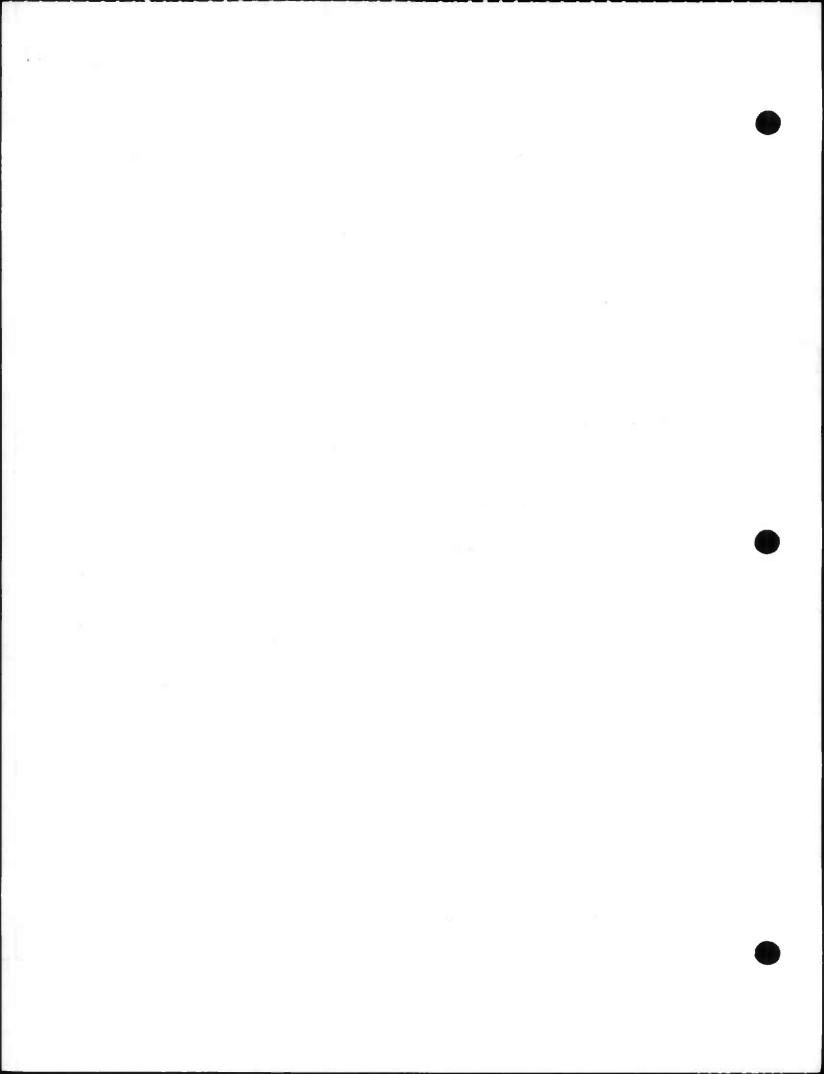
31. OATE FILED (Month, Day, Year)

32. REGISTRAN'S SIGNATURE

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1994 Provenza Joseph December 4 10:10 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 M 2 | 1 HOURS YRS. Oct. 217-26-5473 86 9, 1908 Pennsylvania 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington Reeders Memorial Home Boonsboro RESIDENCE OF DECEDENT 10s. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Frederick Frederick 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOF 10g. CITIZEN OF WHAT COUNTRY? 8005 Glendale 21702 United States Court 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ☐ NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuben, Maxican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE - American Indian, Black, White, stc. 1 Never Married 2 Married Specify: White BY 3 Widowed 4 Divorced 1944-1946 COMPLETED 15. DECEOENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INOUSTRY (Specify only highest grade complete) (Give kind of work done life. Do NOT use retired.) Elementary/Secondery (0-12) College (1-4 or 5+) Shoemaker 6 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) notified at Vincent Provenza Rosa DiFatta BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 8005 Glendale Court Frederick, MD Patricia A. Wolfe be OATE 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of must Garrison Forest 12/8/94 Owings Mills, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITYS tauffer Funeral Homes, P.A 21702 1621 Opossumtown Pike, Frederick, MD medicai 23. PART I Enter the diseases or complications that paused the deeth. Do not enter the mode of dying, such se cerdisc or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate intervai Between IMMEDIATE CAUSÉ (Finel **Onaet and Deeth** the diseese or condition___ anews 18m resulting in death) event, mom 2 traumatic CERTIFICATION Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING other t CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 Injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL any 1 PYES 2 NO OF DEATH? Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only oper, Hem EXAMINER? HOSPITAL: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA sing Home 5 - Residence 6 - Other (Specify) 6 27. MANNER OF DEATH 26c. INJURY AT WORK?
1 YES 2 NO 26s. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 26d. OESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending ВҰ Investigation 2 Accident 28e. PLACE OF INJURY — At homs, fsrm, strest, tectory, office building, stc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 6 Could not be COMPLETED 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT be filed within 72 hours at IMPORTANT: If item 2 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and plecs, and due to the cause(s) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner on stated. 29b. SIGNATURE AND TITLE BE CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) 8 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 20311 Lappans Road, 21713

Boonsboro, Maryland



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and long state death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Secretary Number Name Na		FOR STATE OF MARYLAND 1 - REGISTRAR		MENT OF H		NENTAL HYGIEN REG. NO.		
Max Gardner Pennington, Sr. November 24, 1994, 1257 and 242-36-3574 128 12 19 65 vm. 100 more many to be relieved, yet and the pennington of the pennington					1	2. DATE OF DEATH		3. TIME OF DEATH
Security Numbers S. SECK S. SECK Pays that bringly Favor 1999 Security of particular plants S. SECK S. S		Max Gardner	Penn	ington,	Sr.			
Secretary Description The Secretary Description		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs.	lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		BIRTHPLACE (State or Foreign
BE SECONTY OF DECENT WINDING PROPERTY OF DECENTS WINDING CONTY SOUTH TAMES (FOR PRINCIPLE OF DECENTS) WINDING CONTY SOUTH TAMES STATE SOUTH TAMES SOUTH T		242-36-3574 1 X M 2 □ F 65	YRS.	MONTHS DAYE			929 N	
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Security Security	ER.	116 Sharon Street			21911		U.S.	Α.
Security Security	5						or No 14	. RACE — American Indian,
15. DECERNITY SEVICATION State Control of the properties of t		IE VES CIVE WAR OR DATES	JNO					Specify:
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THE MALING ADDRESS (Sheet and Number or Part Route Humber or Part Route	ן ז	Elementary/Secondary (0-12) College (1-4 or 5+)				Transpo	ortați	on
THE MALING ADDRESS (Sheet and Number or Part Route Humber or Part Route	S C	17. FATHER'S NAME (First, Middle, Lest)			16. MOTHER'S NAM			
Violate R. Pennington 116 Sharon Street - Rising Sun, MD 21911	- 1	McDowell Pennington				Flora Gil	ley	
Violet R. Pennington 116 Sharon Street - Rising Sun, MD 21911 229, METROD PENDSTRIDNIAN STREET 231, MEDICAN DISTRIPTION PROPERTY TO PENDSTRIDNIAN STREET 241, Densition 5 Other (Speedy) 252, MEDICAN STREET 253, METROD STREET 254, NEW AND ADDRESS OF FACILITY HILL MARY HILL 255, PART I. Effect the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory areast, information and leases or condition 257, PART II. Other alignificant conditions, or condition and the street of the stre								ode)
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal stateween constituting in death) 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, internal stateween constituting in death) 23. PART I. Enter the diseases, or complications and the caused on such line. 24. PART II. Enter the diseases, or complications on the constituting in death internal stateween constituting in death) 25. Sequentially list conditions, at any constituting in death but not resulting in the underlying cause given in Part I. 26. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. PART II. Other significant	-		116 S1	haron St		_	-	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 122 Mark And Address of FACHITY HICKS Home for Funerals, P.A. 103 West Stockton Street Elector MD 210_155_21 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Batween Onset and Death disease or condition resulting in death) 3.		20a. METHOD OF DISPOSITION 1 △ Burial 2 □ Cremetion 3 □ Ramoval from Stata □ Cremetery,	CEAND DATE OF	DISPOSITION (Na	me of			
Hicks Home for Funerals, P.A. 103 Nest Stockton Street 22. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death IMMEDIATE CAUSE (Final Cause) In Immediate Cause in Control on a cause on each line. In Immediate Cause in Control on Immediate Cause on Control on Immediate Cause (Pleases or Injury Marcy Disease or Injury Dik To Jon As A Conscouence On: Card Cause (Please or Injury Cause (Please or Injury Dik To Jon As A Conscouence On: Card Cause (Please or Injury Cause (Please Or Injury Cause (Please O			y Hill				rry Hi	11, Maryland
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as certific or respiratory arrest, shock, or heart fishires. List only one cause on each line. MMEDIATE CAUSE (Final disease or condition resulting in death)		1. STATE OF PURENAL SERVICE BICENSEE		Hick	s Home fo	r Funeral:	s, P.A	•
Approximate shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease, or conditions, resulting in death) DUE TO (OR AS A CONSCOURCE OF): Sequentially list conditions, and the course of injury that initiated events resulting in death) DUE TO (OR AS A CONSCOURCE OF): COURSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSCOURCE OF): COURSE (Disease or Injury that initiated events resulting in death) LAST DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF NO. DID TOBACCO		Donald & Huke		E 11- +-	- MD 2	1021-5521		
MMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERTING CAUSE (Disease or Injury		 PART I. Enter the diseases, or complications that caused the shock, or heart failure. List only one cause on each it 	deeth. Do no ine.	ot enter the mo	de of dying, auch	as cerdiac or respi	ratory arrea	
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Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injuny Last) Course, Enter UNDERLYING CAUSE (Disease or Injuny Dig to (on as a consequence op: Course, Closease or Injuny Course op: Course, Course op: Course, Course op: Course, Course op: Course, Cours	ļ	resulting in death) s. MYOCAYCINL-IN	LANCI 12M					
Cause Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART III. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. PART III. Other significant conditions contributions contribution in Part I. PART III. Other significant conditions contribution contribution contribution contribution contribution contribution contribution contribution contribution contribution contributi	,							Znouve
PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL PART 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 1 YES 2 NO 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28a. DATE OF INJURY All hornicides 1 YES 2 NO 28. DATE OF INJURY All hornicides 28b. TIME OF 28c. RUJURY AT 28d. OESCRIBE HOW INJURY OCCURED 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28a. DATE OF INJURY All hornicides 28b. TIME OF 28c. RUJURY AT 28d. OESCRIBE HOW INJURY OCCURED 1 YES 2 NO 28a. DATE OF INJURY — At home, tarm, street, factory, offices 28d. LOCATION (Street and Number or Rural Roune Number, City or Rown, State) 28a. DATE OF INJURY — At home, tarm, street, factory, offices 28d. LOCATION (Street and Number or Rural Roune Number, City or Rown, State) 28a. DATE OF INJURY — At home, tarm, street, factory, offices 28d. LOCATION (Street and Number or Rural Roune Number, City or Rown, State) 28b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P. Michael Glowacki, M.D. — Pencader Corporate Center, Newark, DE 31. DATE FILED (Month, Day, Year) 22 BEGISTRATS SIGNATURE	2	Sequentially list conditions, if any, leading to immediate	SEQUENCE OF					3 60
PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PRIVINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH YES NO	5	CAUSE (Disease of Injury	nt faile	xie -				34-4-5
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4 Homicide A Homicide Building, etc. (Specify) City or Town, State) A Homicide Color No.	6	2 Accident Investigation	home term of			***************************************		
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER C1000371(296. LICENSE NUMBER C1000371(296. LICENSE NUMBER C1000371(P. Michael Glowacki, M.D Pencader Corporate Center, Newark, DE 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	u II	building, etc. (Specify)	rromme, tarrett, acc	reet, tactory, onic		City or Town, State)	and Number or	Hural Houte Number,
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER C1000371(296. LICENSE NUMBER C1000371(296. LICENSE NUMBER C1000371(P. Michael Glowacki, M.D Pencader Corporate Center, Newark, DE 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE		29a. CERTIFIER	4.0	inger in Gi		es come and a		
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P. Michael Glowacki, M.D Pencader Corporate Center, Newark, DE 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE								
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31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (TEM 27) (Type, I	Print)	-10007		11/1	K3//7
31. DATE FILED (Month, Day, Year) NOV 3 0 '94 32. REGISTRAR'S SIGNATURE		P. Michael Glowacki, M.D Pen	cader	Corpora	te Center	, Newark,	DE	
NOV 3 U 94 Gentlemberden - Marie Deviden - Mar		31. DATE FILED (Month, Dey, Year) 32. REGISTRAR'S SIGNATUR	n.J. w					
		NOV 3 0 94 gustan Davidson	harbon	3	_			

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - STATE REGISTRAR	STATE OF MA	RYLAND / DEPA CERTI					MENTAL	HYGIEN	E		
1. DECEDENT'S NAME (First, Middle, Las	v						2. DATE O			YEAR	3. TIME OF DEATH
HERMAN	W.	PHYNES					NOV			94	6:49 AM
4. SOCIAL SECURITY NUMBER		. AGE (In yrs. last birthday	MONTHS	R 1 YEAR	IF UNDER 2	4 HRS.	7. DATE O	F BIRTH Day, Ybar)		8, BIRTH Countr	PLACE (State or Foreign
579-18-1137	1 M 2 F	714 YRS.			HOURS	mine.		15,19	920		SH. D.C.
9e. FACILITY NAME (If not institution, give				•	R LOCATION				9c. COUN	TY OF D	EATH
12507 WHITE	DR.		2	SILVI	ER SPI	RINC	ž .		M	ONTG	OMERY
10e. STATE 10b. COUN	ITY	10c. C	ITY, TOWN	OR LOCAT	ION						10d. INSIDE CITY
MD. MC	ONTGOMERY		S	LLVEI	SPR	TNG					LIMITS?
10e. STREET AND NUMBER					ZIP CODE	-210			10g. CITIZ	EN OF W	WHAT COUNTRY?
12507 WHITE	DR.				20	0904				U.S	Α. Α.
11. MARITAL STATUS	12. WAS DECEDENT I	EVER IN U.S. ARMED						(Specify Yee	or No-	14. RACE	— American Indian.
1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR	YES 2 NO			ecity Cuben, 2 NO			cen, atc.)		Speci	
7.	1	1									BLACK
15. DECEDENT'S EC (Specify only highest gra	de completed)	16e. DECEDENT' (Give kind o life. Do NOT	f work done	during mo	ON st of working		16b.	KIND OF BUS	INESS/INDU	STRY	
Elementary/Secondery (0-12)	College (1-4 or 5+)							FED.	CONTE	п	
17. FATHER'S NAME (First, Middle, Last)	7	EAR	CUTIV	<u>r</u>	16 MOTHS	D'C MAS	ME /Class Ad	ddle, Maiden :			
HERMAN W.	PHYNES	SR.			10. MOTHE					388	
190. INFORMANT'S NAME (Type/Print)	TILINED		IG ADDRES	S (Street a	nd Number o		MABE]	ur, City or Town	SUYI		-
ARTHUR S.	PHYNES	3801						ANO, I			
20e. METHOD OF DISPOSITION		20b. PLACE AND DATE				71110	DATE		CATION — C		
1 Donation 5 Other (Specify)	moval from State	CHAMBERS					1) F			
21. SIGNATURE OF FUNERAL SERVICE	LICENSINE	- 4			D ADDRESS			21 -	CT A TITAL	724111	• 1·II) •
*W. W. CHAMBERS CO. INC., SILVER SPRING, MD.											
23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest. Approximate											
ahock, Dr heart fallure. List Dnly Dne cause Dn eech line. IMMEDIATE CAUSE (Finel											
disease or condition resulting in death)	e. Ileans	His Poll		. 6	brezis						
resulting in death)	DUE TO (O	R AS A CONSEQUENCE	OF):	7	0/4013						1
	b										
Sequentially list conditions, if any, leading to immediate	DUE TO (O	R AS A CONSEQUENCE	OF):								
CAUSE (Disease or injury	С.		_								
thet initiated events resulting in deeth) LAST	DUE TO (O	R AS A CONSEQUENCE	OF):								
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PART II. Other significent condition	ons contributing to de	eth but not resulting	in the u	nderiying	ceuse giv	ven in I	Part I.	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS
								PERFORI			AVAILABLE PRIOR TO COMPLETION OF CAUSE
							_	1 1 123 2	M. NO		OF DEATH?
DID TOBACCO USE CON	TRIBUTE TO CAU	SE OF DEATH Y	ES 🗆	NO P	UNCE	RTAIN	<u></u>				
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DE	ATH (Check	only one)							
1 TES 2 TO	HOSPITAL:	R/Oulpatient 3 🗆 DOA	4 Nu		5 Real	dence (6 🗌 Other	(Specify)			
27. MANNER OF DEATH	28e. DATE OF IN (Month, Day,		ME OF	28c. INJ WO			28d. DEŞC	RIBE HOW IN	JURY OCCU	JRED	
1 Natural 5 Pending 2 Accident Investigation			М		ES 2 🗌	NO					
3 Suicide 8 Could not b	26e. PLACE OF II building, ato	NJURY — Al home, lerm. .: (Specify)	, atreet, Jec	tory, office				TION (Street e. Town, State)	nd Number o	r Aurel A	oute Number,
4 Homicide datermined				_				,			
29e. CERTIFIER 1 CERTIFYING PHY	SICIAN: To the beat of my	knowledge, death occur	rred at the	time, date	end place, e	end due 1	10 lhe caus	e(e) end man	ner ee atate	s,	
one) 2 MEDICAL EXAMI	NER: On the beels of exam	nination end/or investigat	ion, in my	opinion, de	eath occured	d at the t	time, date e	nd place, end	due to the	ceuse(e)	end manner es atated.
296. SIGNATURE AND FITLE OF CONTIN	ER _				29c. LICEN	SE NUM	BER		29d. DATE	SIGNED	(Month, Day, Yeer)
bowle	un no				02	45-	71	[> //	1	194
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
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31. DATE FILED (MOORT), Day, Year)	32. BEGISTRAR'S	SIGNATURE	,								
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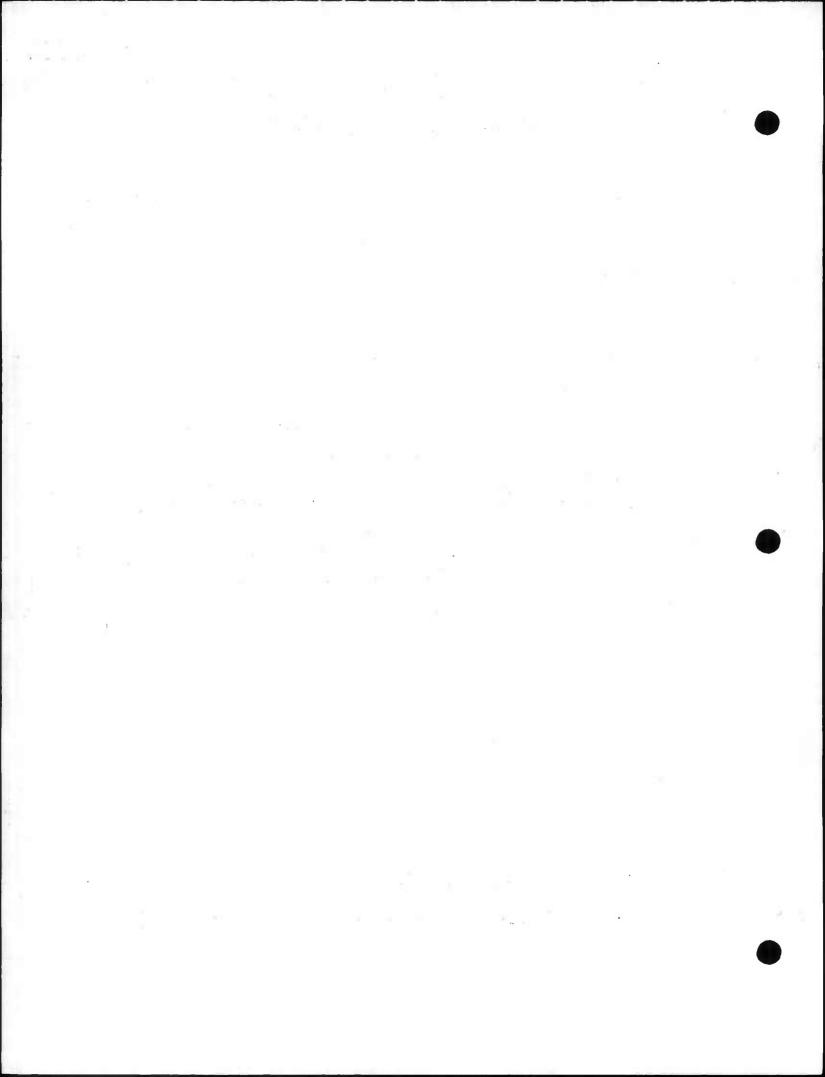
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funeral director, page 5 should rurs after death. signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. death certificate be peen has be. Dept. The law r certificate h L DR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate to hours after death with the State hours FUNERAL I HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH PEG. NO. 2. DATE OF DEATH 3. TIME OF DEATH ham FDWAR YEAR AME MAM 55 25 94 PM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthdey) 7. DATE OF BIRTH (Month, Day, Year, May 27, IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 X M 2 - F 579-12-8105 YRS. 73 1921 Washington, D.C. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Holy Cross Hospital Silver Spring Montgomery RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Montgomery Kensington 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 4001 Lawrence Avenue 20895 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ∑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuben, Maxican, Puetro Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Merried В Specify 3 Widowed 4 Divorced WW II White COMPLETED 15. OECEDENT'S EDUCATION pecify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Sp Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Clerk Federal Government once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) James Edward Peckham Lucy G. Thompson BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary E. Peckham 4001 Lawrence Avenue Kensington, Maryland 20895 pe 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Metropolitan Crematory 11/27/94 Alexandria, Virginia examiner 21. SIGNATURE OF NUMERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reapiratory errest, shock, or heart failure. Ust only one cause on each line. Approximate intarvai Batween IMMEDIATE CAUSE (Final **Onaat and Daath** disease or condition ACCIDENT EREBRO VASCI) LAR WEEK resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL COMPLETION OF CAUSE 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER HOSPITAL: OTHER 1 YES NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Realdence 6 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural Pending 1 YES 2 NO ВҰ 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, factory, affice 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner se stated. 2 ___ MEDICAL EXAMINER: On the beale of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE -26-94 2 PLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 20902 32. REGISTRAR'S, SIGNATURI

Frina Davidson



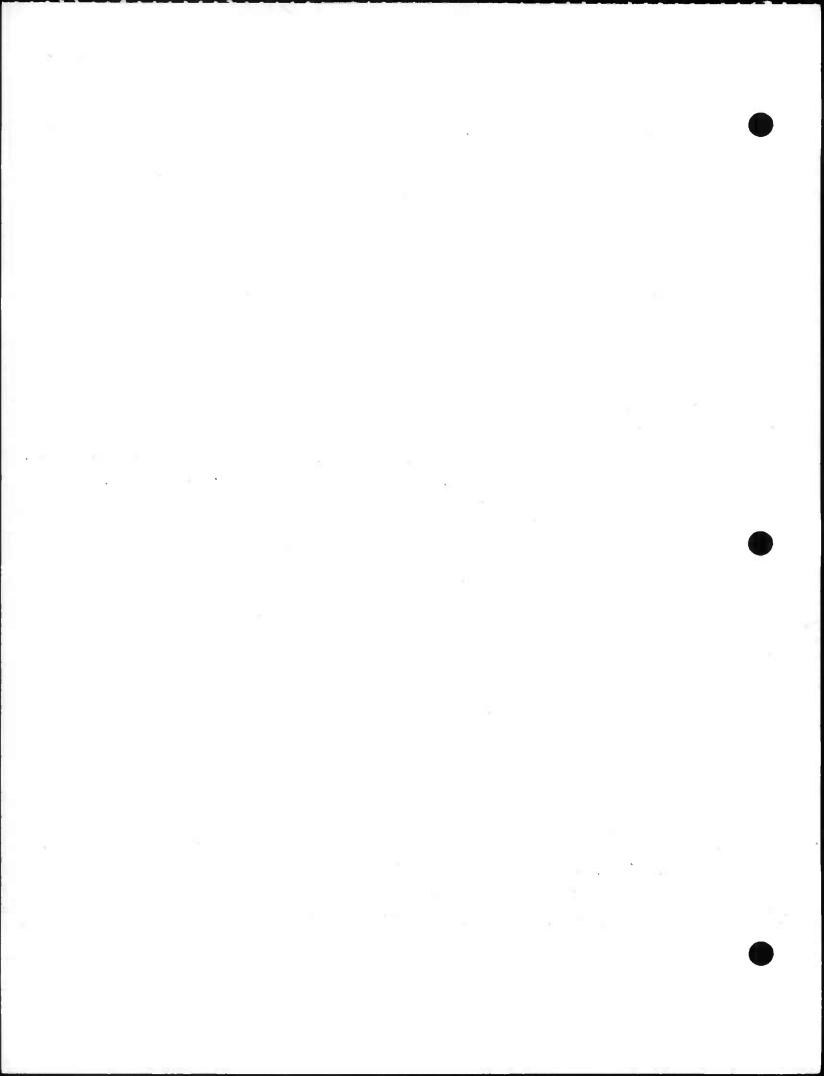
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Flours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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	FOR STATE REGISTRAR	STATE OF MARYLAND		RTMENT OF		D ME	NTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)						DATE OF DEATH		3. TIME OF DEATH
	Hattie Morri	s Papuga					ovember 2		5:30 PM
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. la:	st birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR		DATE OF BIRTH (Month, Day, Year)		THPLACE (State or Foreign intry)
	243-44-0161	1 □ M 2 💢 F 77	YRS.	MONTHS DAYS	HOURS MIN	. Se	ptember		th Carolina
	9a. FACILITY NAME (If not institution, give st	reet and number)		9b. CITY, TOWN	OR LOCATION OF			9c. COUNTY OF	
O.	Manor Care Potom	ac		Potom	ac			Montgo	mery
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CI	Y. TOWN OR LOC	ITION				10d. INSIDE CITY
E I	Maryland Mo	ntgomery	2000	ilver S					LIMITS?
<u> </u>	10e. STREET AND NUMBER	regomery			H. ZIP CODE			10g. CITIZEN O	1 YES 2 NO
ER/	2445 Lyttonsville	Road #100			20910			U.S.	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. AF	RMED		CENDENT OF HIS		RIGIN? (Specify Yes	or No.— 14. RA	ACE — American Indian.
BY F	1 Never Married 2 🕍 Married 3 Widowed 4 Divorced	FORCES? 1 TYPES 2 THE IF YES, GIVE WAR OR DATES	NO		pecify Cuban, Ma S 2 ☑ NO Sp		ierto Rican, etc.)		ack, White, etc.
		WW II							ite
	15. DECEDENT'S EDUC (Specify only highest grade	completed) (G	ECEDENT'S Sive kind of a. Do NOT u	WORK done during n	ION lost of working		16b. KIND OF BUS	INESS/INDUSTRY	=
12	Elementery/Secondary (0-12)	College (1-4 or 5+)			^aa.1.		Tadama1	C	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	μιας	3 W A	1coho1	_		Federal		ment
	Joseph F. Morris				Hatt:		Fowle		
) BE	19a. INFORMANT'S NAME (Type/Print)	19	b. MAILING	ADDRESS (Street			Number, City or Town		20910
2	Joseph A. Papuga	24	445 L	yttonsv	ille Roa	ad #	100 Silv	er Spri	ng,Maryland
	20a. METHOD OF DISPOSITION Burlel 2 Cremation 3 Ramo	20b. PLACE cemetery, cre	AND DATE	OF DISPOSITION (lame of 11/	30/9	PATE 20c. LOC	CATION — City or	
	Donation 5 Other (Specify)	Arling	gton	Nationa	l Cemete	erv	Arli	ngton,V	irginia
	21. SIGNATURE OF FUNERAL SERVICE LIC	INSEE // ////	1	Fran	NO AODRESS OF	FACILIT Coll	ins Fune	ral Hom	e. Inc.
	1/ach -6	. //ellell	_	500	Univers	ity	Blvd.,W.	Sil.Sp	r.,MD 20901
	23. PART I. Entar the diseases, or c	omplicatione that caused the delist only one cause on each line	eath. Do	not enter the m	ode of dying, s	uch as	cardiec or reepir	retory arreet,	Approximate
	IMMEDIATE CAUSE (Finel	h		11			- 1		Interval Between Onset and Death
	disease or condition resulting in death)	DUE TO (OR ASA CONSE	ting	i He	ert 1	-a	elevel		Idad
		DUE TO (OR AS A CONSE	OUENCE O	F):	<i>_</i>	0			
CERTIFICATION	Sequentially list conditiona,	DUE TO (OR AS A CONSE	WZZ	Hor	ery 1	VL	ease		4R.5
TA.	if any, leading to immediate cause. Entar UNDERLYING	1010102	002.1100/0	• 1-					
Ē	CAUSE (Disease or Injury that initiated eventa	OUE TO (OR AS A CONSE	OUENCE O	F):					
ERI	resulting in death) LAST								
	PART ii. Other eignificent conditions	contributing to death but not	resulting	in the underlyis	ng ceuse given	in Part	I. 24a, WAS AN	NITOBEY 2	4b. WERE AUTOPSY FINDINGS
MEDICAL					g couse given	W Care	PERFOR	MEO?	AMILABLE PRIOR TO COMPLETION DF CAUSE
밀							1 🗆 YES 2	NO	OF DEATH?
	DID TOBACCO USE CONTR	IBUTE TO CAUSE OF DEA	TH Y	S I NO F	7 LINCEPT	AINI [- l		1 YES 2 NO
X.	25. WAS CASE REFERRED TO MEDICAL			TH (Check only one		- TITLE			
Sic	EXAMINER?	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	□ DOA	OTHER:	ne 5 🗆 Raalden	ce 6 🗆	Other (Specify)		
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. IN	JURY AT	_	. OESCRIBE HOW IN	JURY OCCURED	
BY	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO				
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At ho building, alc. (Specify)	me, lerm,	street, lactory, offi	en.	281	LOCATION (Street ar City or Town, State)	nd Number or Rura	I Route Number,
릴	29a. CERTIFIER (Check only one)	IAN: To the beat of my knowledge, de	ath occurr	ed at the time, dat	end place, and o	due to Ih	e cause(a) and mann	ner as stated.	
COMPLETED	2 MEOICAL EXAMINER	: On the beels of examination end/or	Investigatio	n, in my opinion,	death occured at 1	the time,	date and place, end	due to the ceuse	e(s) end manner as stated.
BE	296. SIGNATURE AND STILE OF CENTIFIER	-	/_,	net:	29c. LICENSE	UMBER		29d. DATE SIGNE	EO (Month, Day, Year)
٥ ا	1120		1	0	15	3	7	11/2	5794
	30 NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF OEATH (ITE	M 27) (Type,	Print)	1/2	12	7 / 1/	-	3
-	fi. DATE FILEO (Month, Day, Year)	32 MEGISTRAB'S SIGNATURE		10 C	1116	M	who	ealon	ma 20900
	NOV 2 8 1994	Julia Davidson-Ra	ndell						
IL				<u> </u>		_			



TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE MOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with. The most part of may be retained by the hospital or attending physician and completely filled in the trunch director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, at memory

IMPORTANT. It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR		STATE OF MA				HEALTH AND	MENT	AL HYGIEN					
1. OECEDENT'S NAME (First,								E OF DEATH			TIME OF DEAT	N	
` <u>'</u>		Daniel Ja	ames P	opple	ton		No	wember	27, 1	994	3:05	Рм	
4. SOCIAL SECURITY NUMB			AGE (In yrs. Is		IF UNDER 1 YE		7. DATI	E OF BIRTN		BIRTHPL Country)	ACE (State or Fo	reign	
214-36-2517		M 2 □ F	58	YRS.			Ju]	ly 28,	1936		io		
9a. FACILITY NAME (If not ins						VN OR LOCATION OF D							
8750 Georg		nue #326 <i>F</i>	<u> </u>		Si	lver Spri	ng		Montgomery				
10a. STATE	10b. COUNTY			10c. CITY	TOWH OR LO	CATION				10	d. INSIDE CITY		
Maryland	Mont	gomery			Silv	er Spring				1	LIMITS?	NO	
10e. STREET AND NUMBER		11006-				10f. ZIP CODE				_	T COUNTRY?		
8750 Georg						20910				ted S	States		
11. MARITAL STATUS 1 🔀 Never Married 2 🗌		2. WAS DECEDENT E FORCES? 1	YES 2		If yes	DECENDENT OF HISPA , specify Cuban, Maxic	en, Puerto		or No- 1	4. RACE — Black, W	American India /hita, atc.	in,	
3 Widowed 4 Divor	1	IF YES, GIVE WAR	OR DATES		1 🗆	YES 2 NO Spec	Hy:		- 1	Specify:	White	ž	
	EDENT'S EDUCAT		16a. D	ECEDENT'S L	SUAL OCCUP	ATION	16	b. KIND OF BU	SINESS/INDU	STRY			
(Specify only Elementary/Secondary (0-	highest grade coi	College (1-4 or 5+)	lin	Give kind of w e. Do NOT use	ork done during retired.)	most of working							
12				Mail	Clerk			Corpor	rate H	leadqı	uarters	5	
17. FATHER'S NAME (First, Mil						16. MOTHER'S N	AME (First,	Middle, Maiden	Sumame)				
Miller Jo		pleton						May Hoo					
19a. INFORMANT'S NAME (Ty						et and Number or Rural							
Miller J. Po		n				St., #2-					33483		
1 - Burlel 2 - Cremation	n 3 🗆 Remove	al from State	20b. PLACE cemetery, cr	AND DATE O	er place)	₩ ^{an} 30, 199	4 DA		CATION — CI				
20b. PLACE AND DATE OF DISPOSITION 1 Burlei 2 Cremetion 3 Removal from Stata 4 Donation 5 Other (Specify) DATE DONATION DATE DONATION DATE DONATION DATE DONATION DATE DATE DATE DONATION DATE DATE DATE DONATION DATE DATE DONATION DATE DATE DONATION DATE													
ROBERT APPROPRIES OF FACILITY Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501													
23. PART I. Enter the dis	23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, Approximate								ite				
IMMEDIATE CAUSE (Final Onset and Death													
disease or condition resulting in death)	→	Hemope			_	onade							
			AS A CONSE										
Sequantially list condition	ons. b.	Dissec				rysm					ļ		
If any, leading to immed cause, Entar UNDERLY!	lata	טוב זט נטה	AS A CONSE	OUENCE OF									
CAUSE (Disease or Injur		DUE TO (OR	AS A CONSE	OUENCE OF	:								
resulting in death) LAST											į		
PARK II Othersteeling	di .												
PART II. Other eignificer	nt conditions o	contributing to da	ath but not	rasulting ir	tha undari	ying cause given in	Part I.	24a. WAS AN PERFOR		AW	RE AUTOPSY FIN AILABLE PRIOR 1	то	
								1 1 YES 2	□ NO	co	MPLETION OF C		
						_				1 (YES 2 N	10	
DID TOBACCO US		BUTE TO CAUS			(Check only o		IN 🗵						
EXAMINER?	H	IOSPITAL:			OTHER:		10_10						
27. MANNER OF DEATN		28a. DATE OF INJ	URY	26b. TIME		INJURY AT		er (Specify) SCRIBE HOW II	NJURY OCCU	RFO			
	Pending	(Month, Day, 1	(bar)	INJU	RY	WORK? YES 2 NO							
a Contact	ould not be	26a. PLACE OF IN	JURY — At he	ome, farm, at	reet, factory, c	ffica	28f. LO	CATION (Street a	ind Number or	Rural Route	a Number,		
	latermined	building, etc.	(Specify)				City	or Town, State)					
29a. CERTIFIER (Check only 1 CERTI	FYING PHYSICIA	N: To the best of my	knowledge, de	eath occurred	at the time, o	late and place, and du	e to the co	suse(s) and man	ner se stated				
						n, death occured at the					d manner as st	ated.	
29b. SIGNATURE AND TITLE						29c. LICENSE NU					onth, Day, Year)		
256		2	رس	>		D08					, 1994		
30. NAME AND ADDRESS OF	PERSON WHO C											_	
John Taube:	r, M.D.	8218 Wi	scons	in Ave	enue,	Bethesda,	Mar	yland	20814	:			
31. DATE FILED (Month, Day, Y	4 400 4	32. REGISTRAR'S		או הל					-				
	1 1994	CHIMONIA	IIHd Man-	Pandel	-								

DIVISION OF VITAL RECORDS, P.O. BOX 687604

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the mount after death. Page 6 may be retained by the hospital or attending physician.

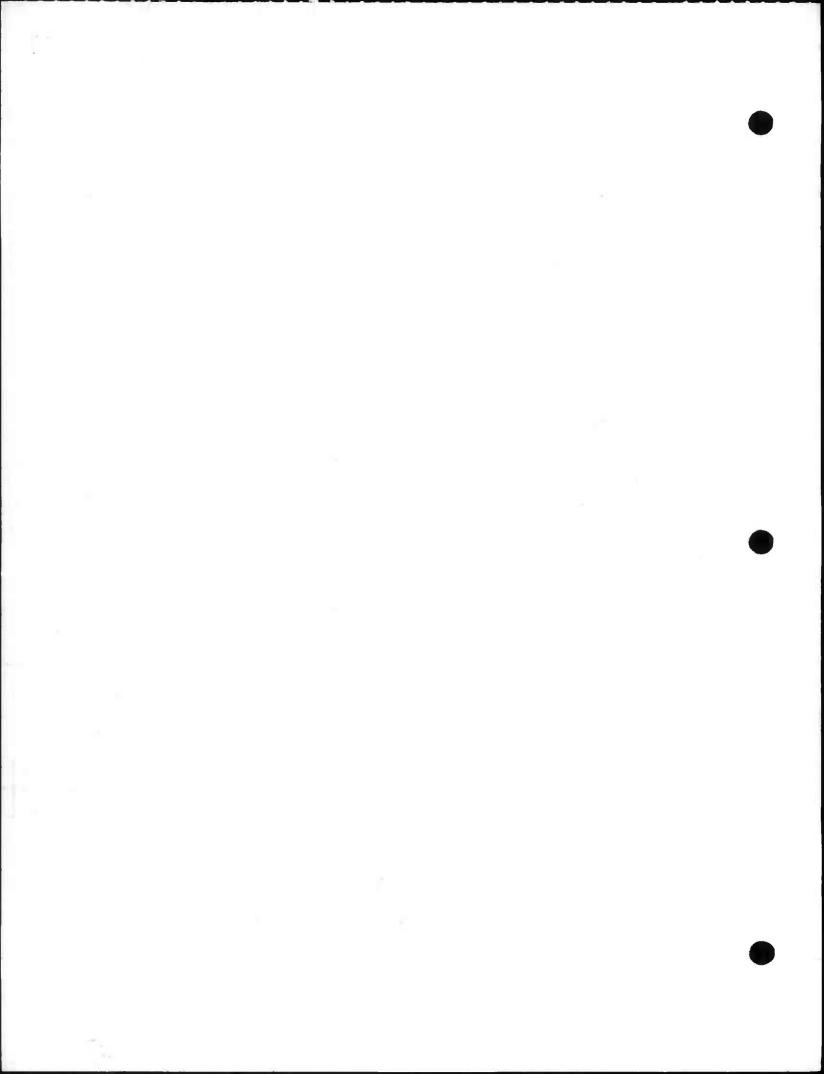
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merial Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	1. DECEDENT'S NAME (First,	Address de la constitución									HEG. NO.			
	1. DECEDENT S NAME (FIRST,		er R. Po							2. DATE O MONTH	DA		YEAR	3. TIME OF DEATN
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs.	In at hirthday)	IE IIMOEI	R t YEAR	IF UNDER		Noven	iber 2	7, 1		1:20 PM
			1 M 2 N F		YRS.	MONTHS	DAYS	HOURS	MIN.	(Month,	Day, Year)		Country	PLACE (State or Foreign y)
	233-40-0796 9a. FACILITY NAME (# not in	ethetian che s		80		01-017	7040	OR LOCATI			4, 19			Virginia
æ						96. CIT				ATH		9c. COU	NTY OF D	EATH
6	Suburban	Hospi	tal			<u> </u>]	Bethe	esda	_		Mc	ntgo	mery
E C	10a. STATE	10b. COUNTY			10c. CIT	TY, TOWN	OR LOCA	TION						10d. INSIDE CITY
DIRECTOR	Maryland	Mor	ntgomery			Ве	ethe	sda						LIMITS?
4	10e. STREET AND NUMBER						10	. ZIP COD	E			10g. CIT	IZEN OF W	/HAT COUNTRY?
FUNERAL	7115 Fai	rfax F	Road					20	814			Un.	ited	States
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S.		13.	WAS DEC	ENDENT (OF NISPAN	IIC ORIGIN?	(Specify Yes	or No-	14. RACE	- American Indian,
BY F	1 Never Merried 2 3 Widowed 4 Divo		IF YES, GIVE Y		AINO			2 X NO			can, etc.)		Specif	tv:
		EDENT'S EDUC												White
1	(Specify only	highest grade	completed)		DECEDENT'S (Give kind of life. Do NOT u	work done	during mo	ON ost of working	ng	16b. F	CIND OF BUS	HNESS/INC	DUSTRY	
2	Elementery/Secondary (0	-12)	College (1-4 or 5	+)		reach					Educ	catio	n	
COMPLETED	17. FATNER'S NAME (First, M	iddle, Last)	3.			reaci	iei	16 MOT	NED'S NAI	ME /First Mis	ddle, Maiden	Cumomo)	_	
	Matthew P	ower								Timot		Surrierre)		
BE	19a. INFORMANT'S NAME (7)		: <u>.</u>		19b. MAILING	ADDRES	S (Street I				r, City or Town	, State, Zic	Code)	
2	Wallace M.	Power									nnati,		,	5208
	20a. METNOD OF DISPOSITI			20b. PLAC	E AND DATE	OF DISPOS	SITION (Ne			DATE	20c. LO	CATION -	City or To	wn, Stata
ŀ	4 Donation 5 Other		oval from Stata		oke C			Nov	. 30	, 199	4 We	llsb	urg vi	irginia
	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE			22. R.C	NAME A	ND ADDRE	SS OF FAC	CILITY	Funer	al H	iome /	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, MD 20814													
	23. PART 1. Enter the gl	seasea, or c	omplications the	t caused the	death. Do	not enter	the mo	MISCO	ING. auch	AVEI	lue, Be	etory an	rest.	D 20814 Approximate
	ahock, Dr h	aart failure.	List only one cau	use on each II	na.									Intarval Between
İ	IMMEDIATE CAUSE (Final disease or condition Cardiac Arrest													
	resulting in death)		pi	(OR AS A CONS		F):		_						24 hours
z			. Нуре	rtensio	n_									Years
5	Sequentially list conditi If any, leading to imme	diate		(OR AS A CONS		,								1
5	cause. Enter UNDERLYi CAUSE (Disease or Inju			rtensiv			ascı	ılar	Dise	ase				Years
CERTIFICATION	that initiated events reaulting in death) LAS	r	DOE TO	(On AS A CONS	EOUENCE U	r):								i l
B			f											
	PART II. Other aignifica	nt condition	s contributing to	death but no	resulting	In the ur	nderiyin	g cause i	given In	Part 1. 2	24a. WAS AN		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICAL										_	TENFOR			COMPLETION OF CAUSE OF DEATH?
ME														1 TYES 2 NO
ż	DID TOBACCO U	SE CONTE	RIBUTE TO CA	USE OF DE	ATH Y	ES 🛚	NO [UNC	ERTAIN	1 🗆			_	
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26. PL	ACE OF DEA	TN (Check								
YSI	1 X YES 2 NO		1 Inpetient 2 2		3 DOA			e 5 □ Ra	aldence	6 🗆 Other (Specify)			
	27. MANNER OF DEATN 1 🔀 Netural 5 🗍 1	Pending	28e. DATE OF (Month, D	'INJURY 'ay, Year)	28b. TIM	URY		RK?		28d. DESC	RIBE NOW IN	JURY OC	CURED	
À	2 Accident	nvestigation	20- 81 405 0	E IN HIEW AN		M		YES 2	NO					
		Could not be satarmined	building,	F INJURY — At etc. (Specify)	nome, term,	street, fact	tory, offic	•		28t. LOCAT	Town, State)	nd Number	or Rural A	oute Number,
COMPLETED	29a. CERTIFIER											·	_	
M M	(Check only		CIAN: To the best of											THE WINNESS SAID
8				xamination and/	r investigatio	on, in my o	opinion, d	eath occur	ed at the t	time, deta a	nd place, and	dua to th	ne cause(a)	end manner as stated.
H	29b. SIGNATURE AND TITLE	OF CERTIFIER	Jour /	9 4	20-0)			3 SY			29d. DAT	E SIGNED	(Month, Day, Year)
၀	20 MANE AND ADDRESS OF	200	/	-20-6	0	-		D	2 (4	10		- /	1112	87 74
	30. NAME AND ADDRESS OF													
	Lila T. Mc(onnel.	L, M.D.	5530 W	iscon	sin .	Aven	ue,	Chev	y Cha	se, M	aryla	and	20815
	NFC N	1 1994	1 Fulia	Davidson-	Pandel	2								
	טבטע	# 100		1-1-0-1		-de								



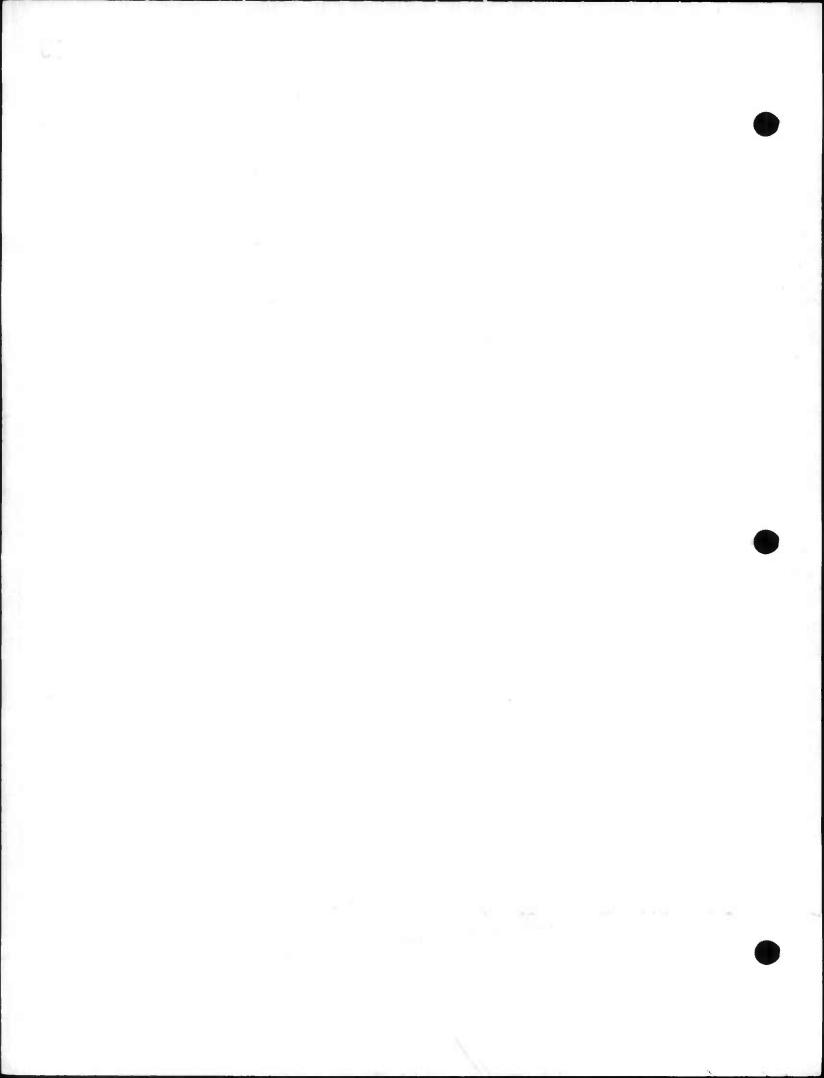
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTM CERTIFICA			MENTAL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Last)	RIA J.			- Perry	2. DATE OF DEATH MONTH DA		S. TIME OF DEATH	
	230-62-5701	I □ M 2 ☒ F	49 YRS. MO	UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) Feb. 20, 1	.945 V	BIRTHPLACE (State or Foreign Country) irginia	
TOR.	98. FACILITY NAME (If not institution, give street Greater Laurel-Bel RESIDENCE OF DECEDENT			Laure	R LOCATION OF DE	ATH	9c. COUNTY Princ	of OEATH e George's	
. DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY, TO	own or Locat	, D.C.			10d. INSIDE CITY LIMITS? 1 YES 2 NO	
FUNERAL	822 Aspen Street,	N.W.			20012			of what country? d States	
B≺	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 K NO	13. WAS DEC	city Cuban, Maxican	IC ORIGIN? (Specify Yes n, Puarto Rican, atc.)	or No- 14.	RACE — American Indian, Black, White, atc. Specify: Black	
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2+ 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY GOVERNment of the District of Columbia								
ÖM	17. FATHER'S NAME (First, Middle, Last)		TIGHT TITLE CT	derve 1		ME (First, Middle, Maiden		OO TUMB TU	
BE (Abraham Richardson	1				(Unknown)			
2	James Perry, Jr.					oute Number, City or Town		· ·	
	20a. METHOD OF DISPOSITION 1 N Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	of from State come	PLACE AND DATE OF DI	ISPOSITION (Na	me of	OATE 20c. LO	CATION — City	or Town, State	
I V	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FORT Lincoln Funeral Home, Inc.								
_	/ /Laise	Duter	4	3401	Bladensh	ourg Rd.,	Brentw	ood, MD 20722	
	23. PART I. Éntar tha diseasea, or cór ahock, or heart failure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in daeth)	it only one cause on ad	ich line.	sth m		i aa cardlec or reapi	ratory erreat	Approximate Interval Between Onset and Death	
Z		DUE TO (OR AS A	CONSEQUENCE OF):						
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury		CONSEQUENCE OF):						
CERTIF	thet initiated events resulting in death) LAST	OUE TO (OR AS A	CONSEQUENCE OF):						
A.	PART II. Other algnificant conditions of	contributing to death but	0 1 10	na underlying) cause givan in I	Part I. 24s. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?	
PHYSICIAN: MEDIC	DID TOBACCO USE CO	ONTRIBUTE TO	CAUSE OF D	EATH Y	ES NO			I VES 2 NO	
CIAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:		26. PL	ACE OF DEATH (Che	ck only one)			
HYS		Inputient 2 ER/Output		Nursing Hom-	5 G Residence	8 Other (Specify) 28d. DESCRIBE HOW II	HIER OCCUP	-	
BY PI	1 Natural 5 Pending Investigation	(Month, Day, Year)	INJURY	WO	RK? ES 2 NO	200. DESCRIBE NOW II	JUNT OCCUR	EU	
	3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, atc. (Special	— At home, farm, stree	t, tectory, office	·	281. LOCATION (Street a City or Town, State)	and Number or F	Rural Route Number,	
COMPLET		N: To the best of my knowled On the bests of examination						suse(s) and manner as stated.	
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER Pri Lew	FA			29c. LICENSE NUM	98 P	29d. DATE SI	GNED (Month, Day, Year)	
5	30. NAME AND ABORESS OF PERSON WHO C	OMPLETEO CAUSE OF OEA	TH (ITEM 27) (Type, Prin	9/0	Cher	RYG LN	# 2 MD	-1/20708	
	31. DATE FILE (1971). 37. (3°) 1994	32. REGISTRAR'S SIGNA	son-Randell						



are after death. Page 6 may be retained by the hospital or attending physician.
In by the kineral director, page 5 should be detached for use as the bufal-transit permit. Pages 1, 2, 3 should removal. BALTIMORE, MARYLAND 21203-3146 DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALLIMONE, IMANILAND	urs after death. Page 6 may be retained by the hos	led in by the funeral director, page 5 should be detach, or removal.	medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, F.C. BOX 13146,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jurs after death. Page 6 may be retained by the hos	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fined in by the funeral director, page 5 should be detach be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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	FOR 1 - STATE REGISTRAR	STATE OF N	MARYLAND /		TMENT				MENTAL	HYGIEN REG. NO.						
	1. DECEDENT'S NAME (First, Middle, Last)			-					2. DATE O	F DEATH			3. TIME	OF DEAT	Н	
	Willie Pal	Lmer							NOV.	. 1	5,19	94	2:2	0 F		M
		. SEX	6. AGE (In yrs. lest	birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF	BIRTH	· ·	8. BIRT	HPLACE (SI			_
	577-54-1820	□ M 2 💢 F	89	YRS.	MONTHS	DAYS	HOURS	MIN.	5/6/	Oey, Year)		ROC	k Hi	11	S	C
	9e. FACILITY NAME (If not institution, give street	t and number)			9b. CITY.	TOWN C	R LOCATIO	ON OF DE		0.5		NTY OF			0	
NO.	Mariner Health		Center				rel						Geo	rge	1 5	5
<u></u> [RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY			10c CIT	Y, TOWN O	R I OCAT	ION						10d, INSI	DE CITY	,	
FUNERAL DIRECTOR	D.C.	N/A			Wash								LIMI 1X YES	TS?		
AL A	10e. STREET AND NUMBER					101	. ZIP CODI				10g. CIT	IZEN OF	WHAT COU	NTRY?		
E.	4231 Blaine	St.,N	.E.				2	001	9			II.	S.A.			
3	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No — 14. RACE — American Indian,															
BY FI																
ا ۾ ا	15. DECEDENT'S EDUCAT	ION	16a, DEC	CEDENT'S	USUAL OC	CUPATIO	ON		16b, F	UND OF BU	SINESS/IN	DUSTRY				
	(Specify only highest grade cor Elementary/Secondary (0-12)	mpleted) College (1-4 or 5 -	(Gh	ve kind of Do NOT u	work done d se retired.)	during mo	at of working	g	- 1							
COMPLETED	7th	conege (1-4 of 5 -	, I	Ome	stic	•				Π.	S.	Sena	ate			
MO	17. FATHER'S NAME (First, Middle, Last)			Onic	SCIC		16. MOTI	HER'S NA	ME (First, Mi			JCIII	100			
BE C	John Hill	L					М	agg:	ie Go	oodma	an					
	19e. INFORMANT'S NAME (Type/Print)								Route Numbe					019		
5	James Bowser						_		St.,N					.с.	_	_
	20e. METHOD OF DISPOSITION 1	al from State	20b. PLACE Cother pla	of dispo	Mem	me of cer	netery, cren	11/	/21/9				own, State			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY															
	H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E.															
	23. PART I. Enter the diseases, or con												Ap	proxim		
	shock, or heart failure. Lis			i										erval B		
	disease or condition	Con	NUNSI	عداد	140,	4	En	:10	10				1 1	Day	1	C
1	resulting in death) s	DUE TO	(OR AS A CONSEC	UENCE C	OF):	47 1	1 4	114	,				- 1	7	7 -	
_		Mil	OCOrdio	al ·	In 1	are	tion	~					4	100	5	
CERTIFICATION	obdocution, not conditions,	DUE TO	(OR AS A CONSEC	UENCE C	OF):	0()	1.00									
	if any, leading to immediata cause. Enter UNDERLYING												ļ			
[윤]	CAUSE (Diseese or injury that initiated events	DUE TO	(OR AS A CONSEC	DUENCE C	OF):											_
토	resulting in death) LAST															
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4	PART ii. Other significant conditions	contributing to	dseth but not r	esuiting	in the un	derlyin	g cause	given in	Part i.	24a, WAS AN		24	Ib. WERE AU			IGS
MEDICAL										1 TYES			OF DEAT	TION OF		E
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NA I	25. WAS CASE REFERRED TO MEDICAL					28. P	LACE OF D	EATH (C)	heck only one)						
SICIAN:		HOSPITAL:	ER/Outpatient 3	□ pos	OTHER	R:										
РНҮ	27. MANNER OF DEATH	28a. DATE OF	Cho Carlin Hi	28b. Til			JURY AT	esidence	8 Other	RIBE HOW	INJURY O	CURED				
	1 Natural 5 Pending	(Month, L			JURY	W	ORK? YES 2	¬ NO	200.000							
B	2 Accident Investigation	20a PLACE (OF INJURY — At ho	ma farm	atmet fact				201 1 0 0 4	TION (Street	and Musel	or Dum	/ Christo Alum	bor		
ETED	3 Suicide 6 Could not be 4 Homicide determined		etc. (Specify)		on set, lace	iory, orin				Town, State		J 01 71070	riodio resin	561,		
삘	29e. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the heat o	l my knowledne de	ath con-	rad at the t	lme dre	and stee	and do	a to the second	a(a) and	Door on at	hate				
MP	(Check only one) 2 MEDICAL EXAMINER:												via) and mo	nner ar	etat	rt.
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w	29b. SIGNATURE AND TITLE OF CERTIFIER	in	.6				29c. LIC	ENSE NU	IMBER		29d. DA		ED (Month, L			
OB	yen	yMa	1 10)			D	450	26			No	v. 1	7,1	99	94
일	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAL	SE OF DEATH (ITE	M 27) (Typ	e Print)										-	

Print) Suite 307 Bowie Rd., Laurel, Md

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

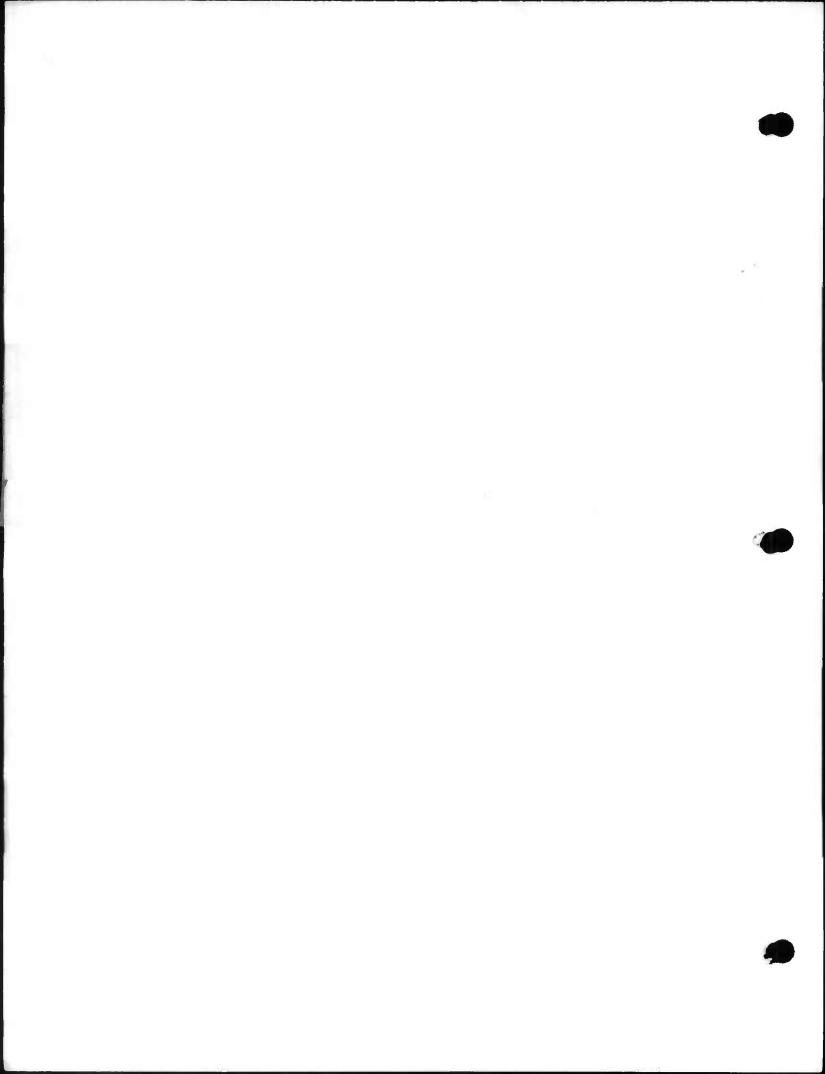
Moy, M.D.

1994

14333 Laurel
32 REGISTRAR'S SIGNATURE

Jenny Y.

31. DATE FILED (Month, Day, NOV 2 8



BALTIMORE, MARYLAND 21215-0020	PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
DIVISION OF VITAL RECORDS, P.O. BOX 68760	within
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HOSPITAL

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the funeral director, page 5 should be detached for use as the burial-transit once. notified at pe must examiner medical filled in by 6 the completely event, burial, other traumatic and attending 6 certificate has been signed by the atter h the State Dept. of Health and Mental injury, shows any 23 item 10 this c marked, After ti 99 DIRECTOR: A hours after d Item 28 is TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 h

CERTIFICATION

MEDICAL

PHYSICIAN:

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permit. Pages 1, 2, 3 should

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FOR		10e,10d,10e,					_	INTY	3707	0
STATE REGISTRAR	OIAIL OI	CERTIF				REG. NO.	-			
ECEDENT'S NAME (First, Middle	e, Last)					2. DATE OF DEATH MONTH DA			3. TIME OF DE	ATH
	Cora E. P	ellerin				Nov. 23	199	4	4:57 P	. M
OCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 Y	AR IF UNDE	R 24 HRS.	7. DATE OF BIRTH			IPLACE (State or I	Foreign
12 28 0784	1 🗆 M 2 💢 F	87 YRS.	MONTHS D	AYS HOURS	MIN.	(Month, Day, Year) Aug. 26 1	907	New	w Hampsh	ire
FACILITY NAME (If not institution	9b. CITY. TO	WN OR LOCAT	ION OF DE	ATH	9c COH	NTV OF D	EATH			

4. S 01 DIRECTOR Collington Episcopal Lifecare Mitchellville Prince George's RESIDENCE OF DECEDENT Ma STATE and 10b. COUNTY ROS George's 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? New Hampshire Grafton. Lebanon 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER #210h 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 10450 Lettsford Rd. 20721-2747 3 Brookside Drive 03766 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, stc. FORCES? 1 YES 2 NO 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: White 1 TYES 2 TO NO Specify: BY 3 😾 Widowed 4 🗌 Olvorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) 4 Elementary School Teacher Education 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) George M. Stacy Janet G. Muir BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John Pellerin Rancourt Estates # 70 Claremont 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State 1 Removal from State
4 Donatton 5 Other (Specify) cemetery, crematory or other place) Valley Cemetery Lebanon N.H. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Beall-Evans Funeral Home, P.A. Kober 16000 Annapolis Rd. Bowie Md. 20715 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Dasth disease or condition resulting in death) Sequentially list conditions, if any, lesding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a WAS AN AUTOPSY 2 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) EXAMINER? HOSPITAL: OTHER 1 TYES 2 NO ng Home 5 Realdence 6 - Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28a. OATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCUREO Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, tarm, street, factory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 29a. CERTIFIER IChack only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the mination and/or investigation, in my opinion, death occured at the time, data and placa, and due to the cause(a) end manner es stated. 29d. DATE SIGNED (Month, Day, Year) 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 25 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (TEM 27) (Type, Print) 31. DATE FILED (Month, Day, War) 32. REDISTRAR'S SIGNATURE AND BE DEC 0 2 1994

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

_	REGISTRAR				CERTIT	ICAL	E OF	DEA	I III	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Lest) ROBERT A Phi					11,05				2. DATE OF DEATH NORTH DAY YEAR 1794 1245				
	4. SOCIAL SECURITY NUMB		5. SEX	6. AGE (In y	rs. lest birthday) YRS,	IF UNDE	R 1 YEAR	IF UNDER	BATAL	7. DATE OF BIRTH (Month, Day, Year)	00/	Country	PLACE (State or Foreign	
				70	THO.					June 23, 1			vailable	
۳ ا	9a. FACILITY NAME (If not Institution, give street and number) Washington Adventist Hospital					96. CITY, TOWN OR LOCATION OF DEATH Takoma Park				TH	9c. COUNTY OF DEATH Montgomery			
Ĕl	RESIDENCE OF DEC						Tuttoma Tatt					Honegomery		
DIRECTOR	10a. STATE	10b. COUNTY			100	TY, TOWN							10d. INSIDE CITY LIMITS?	
							Capital Heights				1 🖔 YES			
FUNERAL	10e. STREET AND NUMBER					101. ZIP CODE 20743			U.S.A.			HAT COUNTRY?		
¥ I	11.16 Ute Way 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARME					MED 13. WAS DECENDENT OF HISPANIC				C ODIGINS (Secold) Vec	- American Indian.			
	1 X Never Married 2 Married FORCES? 1 X YES 2 NO				2 NO	If yes, specify Cuban, Mexicon			n, Mexicen,	, Puerto Rican, etc.) Black, Wh			White, etc.	
ă	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES					1 ☐ YES 2 ☒ NO Specify:				Specify: White				
COMPLETED	15. DECEDENT'S EDUCATION 18a. DE (Specify only highest grade completed) (G				a. DECEDENT'S	ECEDENT'S USUAL OCCUPATION Give kind of work done during most of working to Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY				
Z.	Elementery/Secondary (0	-12)	College (1-4 or 5 -		Plumber					Private				
N N	17. FATHER'S NAME (First, Middle, Lest)				. I dimber									
	Ralph	P	hillips			18. MOTHER'S NAME (First, Middle, Maiden Surname) Beulah Louree Knorleine						2		
O BE	19a. INFORMANT'S NAME (7)	/pe/Print)			19b. MAILIN	ADDRES	S (Street a	nd Number	or Rural Ro	oute Number, City or Tow	n, State, Zip	Code)	20747	
-	Paul D. Wrig								e, Sı	ite 101,				
	20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetery, cremetery or other place) MD National Memorial Park 11/25/94 Laurel, Mary								aryland					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE						22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A.							
	4739 Baltimore Ave., Hyattsville, MD 20781													
	ahock, or he	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, abock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death disease or condition												
	resulting in death)	,	DUE TO	ION AS A C	INSEQUENCE (FFE (1	10.00	M					
NO.	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted evants DUE TO FOR AS A CONSEQUENCE OF: DUE TO FOR AS A CONSEQUENCE OF:													
CERTIFICATION														
HH	resulting in death) LAST		4		U					1				
										WERE AUTOPSY FINDINGS				
EDICAL										PERFORMED?			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
WE													OF DEATH?	
z I	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN													
SICIA	25. WAS CASE REFERRED TO MEDICAL FYAMINER? A 26. PLACE OF DEATH (Check only one)													
	1 YES 2 HO Spitant 2 ER/Outpetlent 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)													
N PHY	27. MANNER OF DEATH 1 Natural 5 Peoding Investigation 282 OATE OF INJURY 286. TIME OF INJURY WORK? 1 YES 2 NO 286. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO													
EDB	3 Suicide 6 Could not be building etal (Specify) 28e. PLACE OF INJURY — At home, farm, building, etal (Specify)						street, factory, office 38f. LOCATION (Street and Number or R City or liver, State)					or Auni A	oute Number,	
	29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the Meet of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
COMPLE	One) 2 MEDICAL EXAMINET: On the basis of examination against investigation, in my opinion_death occursed at the time, date and place, and due to the cause(s) and manner as stated.													
H H	290. SIGNATURE AND TITLE OF CERTIFIER 290. SIGNATURE AND TITLE OF CERTIFIER 290. OATE SIGNED (Moreth, Cloy, Ibiar)													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 37) (High Pint)							637	39						
NOV 2 8 1994 Julia Davidoon Pandala														
	MICALL O	N 1334	Graha	Laurdon	w-Navior	,								

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physician.	by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit per		
hours after death. Page 6 may be retained by the hospital or attending physician	Tuse as the		
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JIDOU	ly filled in	ation, or r	
cuted with	d complete	and Mental Hygiene prior to burial, cremation, or removal,	
ate be exe	nysician an	prior to b	
at the death certificate be executed with	iffending pl	tal Hygiene	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760

HOSPITAL OR ATTENDING PHYSICIAN: The law

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Franklin Thomas Price 994 11:45 AMM November 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 216-70-9152 1 XM 2 | F Feb. Washington, DC Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Manor Care Largo DIRECTOR Prince George's Largo RESIDENCE OF DECEDENT 10b. COUNTY 10a, STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Suitland Maryland Prince George's 1 TES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5200 Belgreen Street #301 20746 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Morried Specify: BY 3 Widowed 4 Divorced Caucasian COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) 12th College (1-4 or 5+)
N/A Carpenter's Assistant Construction Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Edith Ellen Tudgay Harold Norman Price, Sr. BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 5200 Belgreen St. #301 Suitland Maryland 20746 Yvonne D. Price pe 20a METHOD OF DISPOSITION
1 Deuriel 2 Cremation 3 | | 20b. PLACEAND DATE OF DISPOSITION (Name of NOV. 230ATE 20c. LOCATION - City or Town, State must Resurrection cemetery 4 Donation 5 Other (Specify) 1994 Clinton Maryland 21. SIGNATURE OF SOMMAL SERVICE LICENSE examiner 22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md lar medical 23. PART I. Enter the diseases, or complications that caused the desence, or heart fellure. Let only one ceuse on each line. ications that caused the deeth. Do not enter the mode of dying, auch as cerdiac or respiratory arrest? Approximate Interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition 10/94 Metastatic Malignant Melanoma event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF) other traumatic CERTIFICATION 10/94 Metastatic Melanoma to Brain Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING Pelvis and Cecal Mass CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST in uny. PART II. Other significent conditione contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL shows any Seizure Signed 1 YES ZIXNO OF DEATH? Anemia 1 YES 2 NO t, of l certificate has be h the State Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER:
4 X Nursing Home 5 Residence 8 Other (Specify) 1 Inpetient 2 ER/Outpetient 3 DOA 6 i. After this cer r death with the is marked, o 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 5 Pending Investigation 1 YES 2 NO BY 28e. PLACE OF INJURY — A1 home, 1erm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town. State) DIRECTOR; A hours after de item 28 is 69 ETED. 6 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner se stated. COMPLE TO THE HOSPITAL TO THE FUNERAL C De filed within 72 h MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner se stated. D TITLE OF CERT 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 0

WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE Pandale

Rakesh Arora M.D.

1994

31. DATE FILED (MONT), Day 2

D20108

14300 Gallant Fox Lane #222 Bowie Maryland 20715

DHMH-16 Rev 1/8

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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 687604

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be described in use as the bunial-train	be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to bunal, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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sit permit. Pages 1, 2, 3 should

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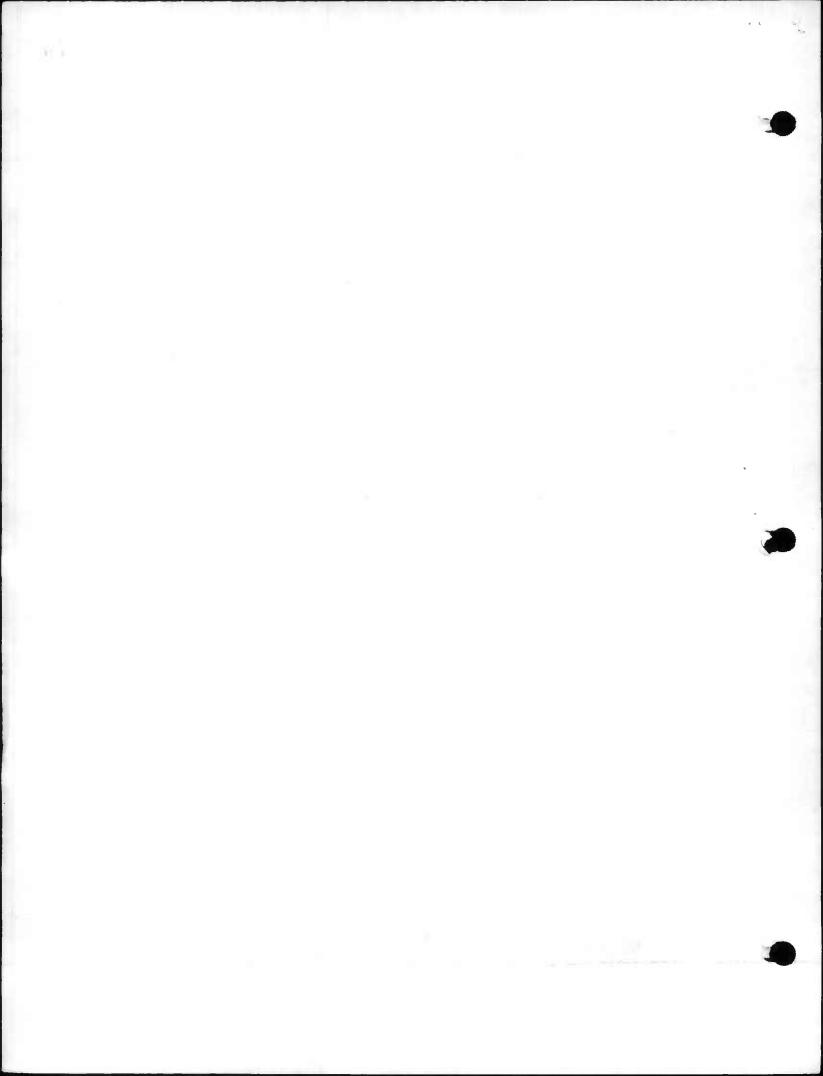
	1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH S. TIME OF DEATH MONTH DAY YEAR 3. TIME OF DEATH									
	ADOLPH HEN	YNE			No	OVEMBER 2	12:58 AM			
			in yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24	4 HRS. 7.	DATE OF BIRTH (Month, Day, Year)	8. B	MRTHPLACE (State or Foreign country)	
	577-42-9407	ŠM2□F 6	4 YRS.	MONTHS DAYS	HOURS	MIN.	01-04-3		ash. D.C.	
	9a. FACILITY NAME (If not institution, give street a	*		96. CITY, TOWN	OR LOCATION	OF DEATH		9c. COUNTY (OF DEATH	
OR	PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S									
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY									
H	Maryland Prince	George's		Lando					10d. INSIDE CITY LIMITS? 1 🔯 YES 2 🗌 NO	
	10e. STREET AND NUMBER			. ZIP CODE			10a CITIZEN	OF WHAT COUNTRY?		
FUNERAL	7509 Hawthorne St				785			d States		
3					HISPANIC (ORIGIN? (Specify Yea	or No.— 14. F	RACE — American Indian.		
		FORCES? 1 X YES	ATEO	If yes, sp	s, specify Cuban, Maxican, Puarto Rican, etc. YES 2 X NO Specify:				Black, White, etc.	
BY	3 Widowed 4 Divorced 8	/1/51 - 4	4730/53		- 23	opoury.			Black	
H	15. DECEDENT'S EDUCATIO (Specify only highest grade comp	N Neted)	(Give kind of	USUAL OCCUPATE	ON ost of working		16b. KIND OF BUS	INESS/INDUSTR	ay	
ا بر	Elementary/Secondary (0-12) Co	illege (1-4 or 5 +)	Iffe. Do NOT use retired.)					Government		
COMPLETED			ria I	T CTETA					L	
8	17. FATHER'S NAME (First, Middle, Last) John Heni	rv Pavne					(First, Middle, Meiden : Dorsey	Sumame)		
H	19a. INFORMANT'S NAME (Type/Print)	-y rayne	40h MAH (NC	AODREOG (Ommer			e Number, City or Town			
2	Eula Mae Payne						Landov			
	METHOD OF OISPOSITION Cremetion 3 Removal 1	20b	. PLACE AND DATE					CATION — City of		
	Cremation 3 Removal 1	rom State cem	elery, crematory or o	ther place)		eme				
	21. SIGNATURE OF FUNERAL SERVICE LICENSUS 22. NAME AND ADDRESS OF FACILITY									
	STEWART FUNERAL HOME									
\dashv	4001 Benning Rd. N.E., Wash. D.C.									
	23. Panel. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or reepiratory erreet, ahock, or heary feliure. List only one cause on each line. Approximate interval Between									
	Musical Cause (Finel								Onset and Death	
i	a	, DUE TO (OR AS A	CONSEQUENCE OF	PI:	10/20	9 40				
_	Sequentially list conditions. Acute Myocardial Inferrefron Due to (of as a consequence of): Sequentially list conditions. Due to (of as a consequence of): Sequentially list conditions.									
CERTIFICATION	if any, leeding to immediate									
CA	CAUSE (Disease or Injury									
H	that initieted eventa resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):								
Ä	d									
	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
DICAL	FINI) STAGE WID WERE INSPORTED ON DIPLOYS PERFORMED? MAILABLE PRING TO COMPLETED OF CAUSE									
MED	OF DEATH?									
2 3	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 NO NAMED IN THE 2 N									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
Sic		SPITAL:	atient 3 DOA	OTHER: 4 Nursing Hom	e 5 🗆 Resid	dence 6	Other (Specify)			
동	27. MANNER OF OEATH	28a. OATE OF INJURY (Month, Day, Year)	28b. TIM		URY AT	28	d. DESCRIBE HOW IN	JURY OCCURE	D	
BY	1 Pending 2 Accident Investigation				rES 2 🗌	NO	_	_		
	3 Suicida 6 Could not be	28s. PLACE OF INJURY building, atc. (Speci	— At home, ferm, s	street, tactory, offic		281	28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
	4 Homicide detarmined									
7	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated.									
ш	296. SIGNATURE AND TITLE OF CERTIFIED 29d. DATE SIGNED (M									
TO B	Often la		16089							
F	30. NAME AND ADDRESS OF PERSON WHO CON	Print)	1 1 1 1 1 1 1 1							
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) STEVEN M. POLLAK MD 7525 Green Way CTR Dr. Greenbell UD 70770 31. DATE FILEO (Month, Day, Year) NOV 2 9 1994 June Day doon-Randalle									
	31. DATE FILEO (Month, Day, Year) 32. REGISTRAP'S SIGNATURE AND ALL OF THE PROPERTY OF THE P									
	NOV 2 9 199	7 June x	100 (000)							

1 - FOR STATE REGISTRAR

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13146,	-
, P.O. BOX	
P. 0.	
DIVISION OF VITAL RECORDS,	And the second of the second second second second
OF VITAL	
DIVISION	

J. DATE OF BIRTH (Month, Day, Year) Jan. 7,19 EATH INIC ORIGIN? (Specify Year) Inic Origin? (Specify Year) Inic O	914 I 9e. COUNTY O HOWAT 10g. CITIZEN O USA a or No— 14. F	10d. INSIDE CITY LIMITS? 1 YES 2 NO OF WHAT COUNTRY?
INIC ORIGIN? (Specify Years, Puerlo Ricen, atc.) 16b. KIND OF BUS State AME (First, Middle, Maiden	914 I 9e. COUNTY O HOWAT 10g. CITIZEN O USA a or No— 14. F	OF DEATH COUNTY 10d. INSIDE CITY LIMITS? 1 YES 2 NO OF WHAT COUNTRY? A RACE — American Indian, Black, Whita, etc.
INIC ORIGIN? (Specify Years), Puerto Rican, atc.) 18b. KIND OF BUS State AME (First, Middle, Maiden	10g. CITIZEN 6 USA	OF DEATH Cd County 10d. INSIDE CITY LIMITS? 1 YES 2 NO OF WHAT COUNTRY? A RACE — American Indian, Black, Whita, etc. Specific.
an, Puerto Rican, atc.) 16b. KIND OF BUS State AME (First, Middle, Maiden	USA u or No-	10d. INSIDE CITY LIMITS? 1 YES 2 NO OF WHAT COUNTRY? A RACE — American Indian, Black, Whita, etc.
an, Puerto Rican, atc.) 16b. KIND OF BUS State AME (First, Middle, Maiden	USA n or No- 14. E	1 YES 2 NO OF WHAT COUNTRY? A RACE — American Indian, Black, Whita, etc. Specific.
an, Puerto Rican, atc.) 16b. KIND OF BUS State AME (First, Middle, Maiden	USA n or No- 14. E	OF WHAT COUNTRY? A RACE — American Indian, Black, White, etc. Snactive
an, Puerto Rican, atc.) 16b. KIND OF BUS State AME (First, Middle, Maiden	n or No— 14. F	RACE — American Indian, Black, White, etc.
an, Puerto Rican, atc.) 16b. KIND OF BUS State AME (First, Middle, Maiden	S	Black, White, etc.
State State AME (First, Middle, Malden	SINESS/INDUSTF	
AME (First, Middle, Maiden		RY
AME (First, Middle, Maiden	Highwa	ay Dept.
h Gooden		
Route Number, City or Town		
Columbia,		
	pokane,	or Town, State , Washington
ACILITY 11 Home, P.	Α.	
y, Marylan		3
dut		Interval Batwo
		Year
Part I. 24a. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDI AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO
Check only one)		
6 Other (Specify)		
28d. OEŞCRIBE HOW I	INJURY OCCURE	ED
261. LOCATION (Street City or Town, State)		Rurel Route Number,
		ause(a) and manner as state
	29d. DATE SIG	GNED (Month, Day, Year)
UMBER 5770	ひんて	, Geni
5770		
	at the time, data and place, a	at the time, data and place, and due to the cost the time, data and place, and due to the cost the time of the cost that the time of the cost that the time, data and place, and due to the cost that the time, data and place, and due to the cost that the time, and the cost the time, and the cost the t

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



BALTIMORE, MARYLAND 21215-0020	certificate be executed within Jours after death. Page 6 may be retained by the hospital or attending physicia	
B	after o	
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.O. BOX 68760,	executed	
S	8	
8	ate	
0	certific	

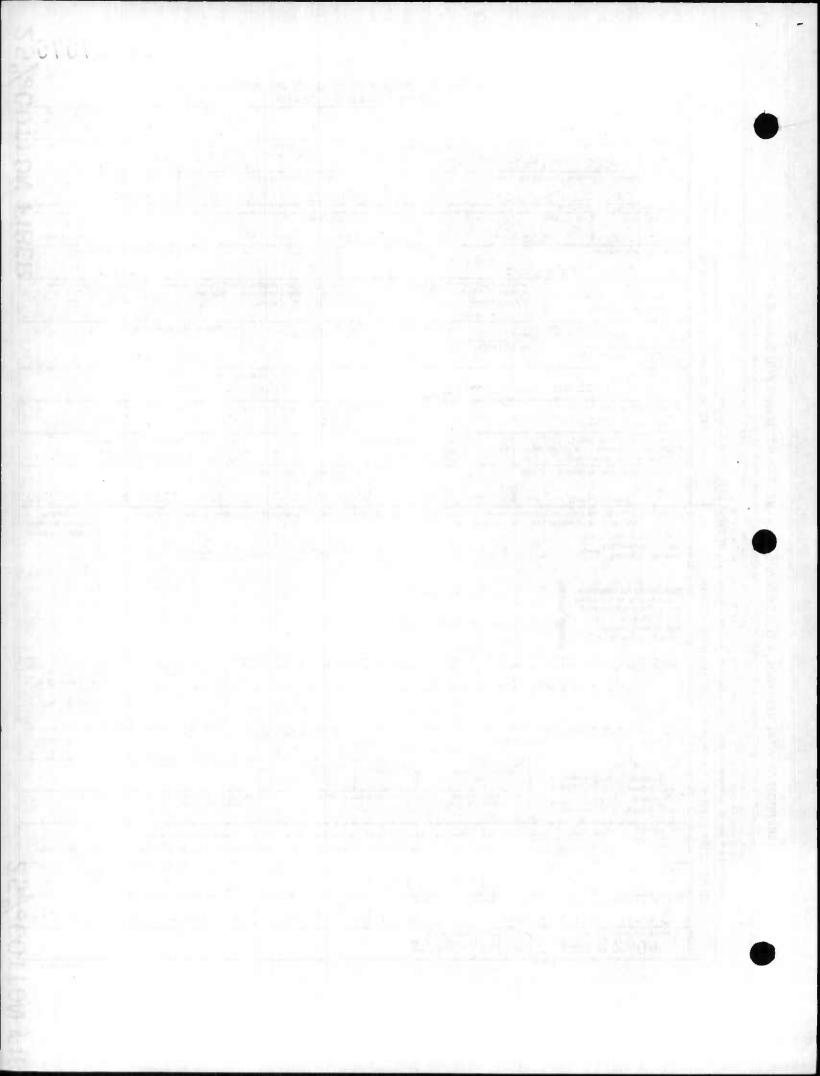
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Cours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH		
Thomas A. Pattis	on	Nov. 17		
A SOCIAL SECURITY NUMBER	5 SEY 8 AGE (in you look highday) of tappen a wear of tappen as you	T DATE OF BURTH		

	1. DECEDENT'S NAME (First,	, Middle, Last)							2. DATE OF DEATH	DAY	YEAR	3. TIME OF DEATH		
	Thomas A.	Pattis	on						Nov.		1994	10:30 am		
	4. SOCIAL SECURITY NUMBER	DER	5. SEX	8. AGE (in yrs. las	t birthday)	IF UNDER		IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Yea		8. BIRTI	HPLACE (State or Foreign		
	213-10-436	2	t√ M 2 □ F	77	YRS.	MONTHS	DAYS	HOURS MIN.	March 21			ryland		
	9a. FACILITY NAME (If not in	stitution, give s	treet end number)			9b. CITY	TOWN (OR LOCATION OF E	DEATH	9c. CO	UNTY OF E	DEATH		
DIRECTOR	5020 Lake		-East			Co	lumb	ia,		He	oward			
H	10a. STATE	10b. COUNT	Y		10c. CIT	Y, TOWN C	R LOCA	TON	10d. (
0	Maryland	Но	ward		Co	1umb	ia		LIMITS?					
FUNERAL	10e. STREET AND NUMBER						10	ZIP CODE	WHAT COUNTRY?					
9	5020 Lake	Circle						21044			U.S.			
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1X YES 2 NO IF YES, GIVE WAR OR DATES W.W. II						f yes, sp		ANIC ORIGIN? (Specify an, Puerto Rican, atc. lly:			E — American Indian, k, White, etc. hy: White		
COMPLETED	15. DEC	EDENT'S EDU	CATION COMPOSite (1)			USUAL O		ON st of working	16b. KINO OF	BUSINESS/II	DUSTRY			
	5 rs Second		College (1-4 or 5 +	·) life.	Do NOT u	se retired.)	runny me	st or working		1 20		don't sale		
MP				FC	rema	n			Gener	al Mo	tors			
BE CO	17. FATHER'S NAME (First, M Elwood Pat								ame (First, Middle, Me en V. Pet					
TOB	Grace Patt								, Columbi)44		
	20e. METHOD OF DISPOSIT. 1 ScBurlel 2 Cremetic 4 Donation 5 Other	n 3 🗆 Rem	oval from State	20b. PLACE / cornetery, cre Crest				nme of		LOCATION -		own, State		
	21. SIGNATURE OF FUNERA		CENSEE /	OTCOL	awii	22.	NAME A	ND ADDRESS OF F	ACILITY			ite, na.		
	* Har	res 5	H. W.	Take	>				ke Funera mbia Pike			City,Md21043		
MEDICAL CERTIFICATION	disease or condition resulting in dasth) Sequentistly list condit if any, leading to immecause. Enter UNDERLY, CAUSE (Disease or injuthat initiated events resulting in death) LAS	diate ING Iry	b	OR AS A CONSECTION OF A CONSECTION OF AS A CONSECTION OF A CON	DUENCE O	F):		onc	ance					
- 1	PART II. Other significa	olek	s contributing to	death but not r	esuiting	In the un	derlyin	g cause given in	PER	AN AUTOPS' FORMED?	7 24	D. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	O MEDICAL	HOSPITAL:			OTHER		ACE OF DEATH (C	theck only one)					
KSI	1 TYES 2 NO		1 Inpatient 2			4 🗆 Nun	sing Hom	/	6 Other (Specify)					
ву Рн	1 Netural 5	Pending Investigation	26a. DATE OF (Month, Da		26b. TIN	IE OF JURY M	28c. IN. WC	RK?	28d. DEŞCRIBE HO	W INJURY O	CCURED			
		Could not be determined	28e. PLACE Of building,	F INJURY — Al ho atc. (Specify)	me, ferm,	street, fact	ory, offic	•	281. LOCATION (Str City or Town, S		er or Rural	Route Number,		
COMPLETED	onal								e to the cause(e) end			e) end manner ee stated.		
BE	29b. SIGNATURE AND TITLE	W	Ma	men	W	n		29E VICENGE I	7919	29d. D/	ATE SIGHE	1090		
2	30. NAME AND ADDRESS OF	PERSON WH	COMPLETED CAUS	SE OF DEATH (ITE	M 27) (7/p)	ATM	JA	POLIS	RPE	im	UT (17y 21042		
	NOV 2 2	1994		ars signature Lear Randa	t,									



BALTIMORE, MARYLAND 21215-0020

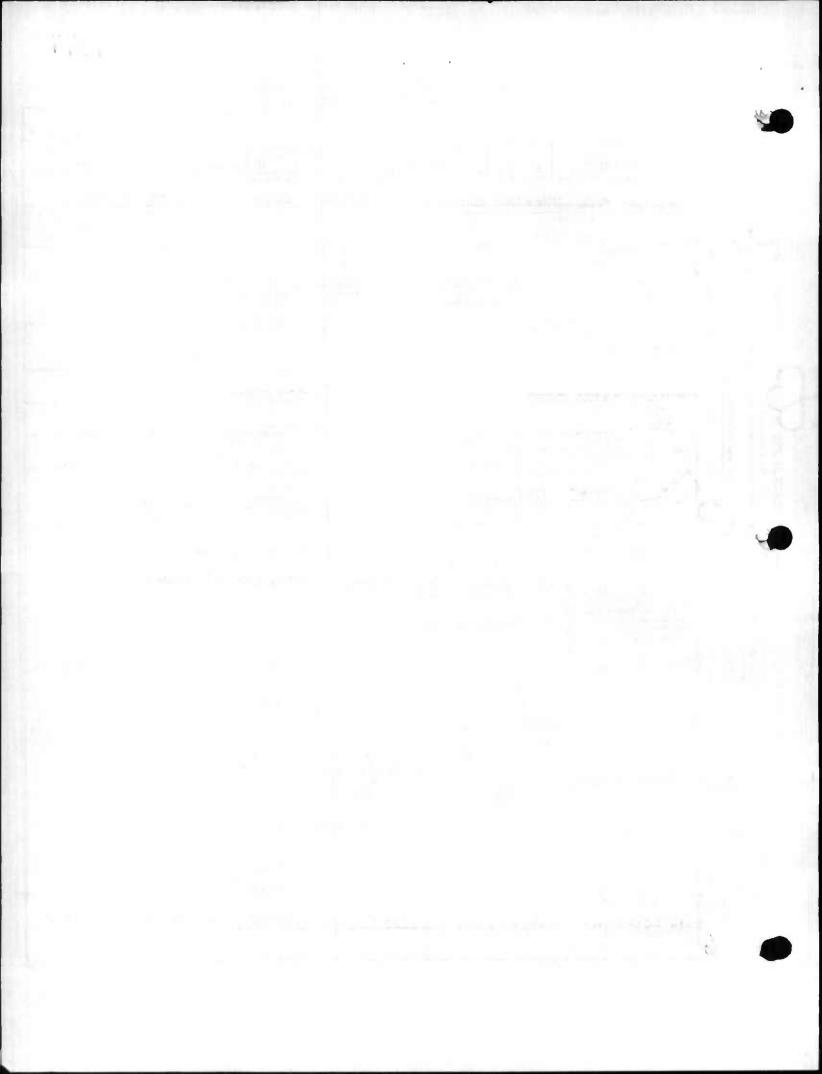
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

							10711		שבת		net	i. NO.		
		1. DECEOENT'S NAME (First									2. DATE OF OE	TH	YEAR	3. TIME OF DEATH
		Maurice		ther P	eacoc	ck, s	Sr.				11 -	24- 9		10:30 P. M
		4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In y	rs. lest birthday		R 1 YEAR	IF UNDER		7. DATE OF BIR (Month, Day, 1		8. BIRTH	PLACE (State or Foreign
		213-05-20	080	1 🔀 M 2 🗌 F	84	YRS.	MONTHS	DAYS	HOURS	MIN,	4-20-		Country	th Caroli
3 should		9a. FACILITY NAME (If not in	nstitution, give s	treet and number)			9b. CIT	Y, TOWN	OR LOCATI	ON OF DE	ATH	9c. COI	JNTY OF OR	
	E I	Hannigan	Ноше	n Nissa a i	- IIC	\		a						
1. 2,	СТОВ	Harrison RESIDENCE OF DEC	CEDENT	NUFSI	ng HC	me	1	Sno	H wc	111		Wo	rces	ter
Sade	DIRE	10a. STATE	10b. COUNTY	Y		10c. C	TY, TOWN	OR LOCA	TION		*			10d. INSIDE CITY LIMITS?
. 		Md.	Wo	orceste	r			Sno	w Hi	11			ŀ	1 TYES 2 NO
EL Sectu	AL	10e. STREET AND NUMBER						10	H. ZIP COD	E		10g. CI	TIZEN OF W	HAT COUNTRY?
physician. burlal-transit permit. Pages 1.	ERAL	204 S. (Church	Stree	t					2186	5.3	11	.S.A	
ician Il-tra	FUN	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.	S. ARMED	13.	WAS DE			HC ORIGIN? (Spec			- American Indian,
phys		1 Never Married 2		FORCES?	YES 2	NO NO		If yes, sp	pecify Cuba	n, Mexica	n, Puerto Rican, e	(c.)	Black	, White, etc.
fing the	BY	3 X Widowed 4 Divo	erced	W 120, GIVE	- ON DAIL			I _ YES	3 5 ∑ KNO	Specify			Specif	white
e as	9		EDENT'S EDU		16	a. DECEDENT	S USUAL C	CCUPATI	ON		16b. KIND	F BUSINESS/IN	DUSTRY	MILLE
or aft	<u> </u>	Elementary/Secondary (0	y highest grade	College (1-4 or 5	4)	(Give kind o	f work done use retired.)	during m	ost of working	ng				
the hospital of detached for once.	립	11	,,	50mgg (1-4 b) 3	"	Manag	red i	11 t i	liti	0.5	East	ern S	hore	Gas Co.
e hos	COMPL	17. FATHER'S NAME (First, M	liddle, Last)			· · · · · ·	, ca	u (1 .	_		ME (First, Middle, I		HOLE	Gas Co.
Pe de de	Ü	Paul E.	Peace	ock					1				1-	
pand bond	00	19a. INFORMANT'S NAME (-	JCK		T 40b MAIL IN	C ADDRES	C (0			odlin I			
fours after death. Page 6 may be retained by the hospital or attending physician. d in by the funeral director, page 5 should be detached for use as the burial-tran or remoral. medical examiner must be notified at once.	일	Peggy Pri											, ,	1060
ay be		20a. METHOD OF DISPOSIT								St.	,Snow			
ector, p		X Burlel 2 ☐ Crematic	on 3 🗆 Reme	oval from State	cemeter	ACE AND DAT ry, crematory or	other place)			1	oc. LOCATION —		
direct direct m		4 Donation 5 Other			_ Wh	atcoa					11/27	Snow	Hill	,Md.
ter death. Page 6 m the funeral director, wal.		21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE		•	22.	. NAME A	ND ADORE	SS OF FAC	CILITY			
death. F funeral funeral examin		Talrie	ia o	1. De	nn	6	ח	ann:	ie F	iinar	al HOr	o Sno	., цт	11 MA
n by the removal		23. PART I. Enter the d	Iseases, or o	complications the	t caused th	a death. Do								Approximate
filled in by the on, or remove the medical		ahock, or h	eart failura.	List only one cau	se on each	ilne.			ou or dy	ing, addi	Too Cardiac Of	respiratory at	1000,	intarval Between
e Pille		iMMEDIATE CAUSE (Fir disease or condition	rel											Onset and Death Several
m		reaulting In deeth)	→	· rheum	atoid	arth	rit	is						
completely fal, cremati				OUE TO	(OR AS A CO	NSEQUENCE	OF):							years
e be executi sician and c rior to buria traumatic	NO	Sequentielly list conditi	lone.	b										
be existence or to	Ē	if any, leading to imme- cause. Enter UNDERLY	diate	OUE TO	(OR AS A CO	NSEQUENCE	OF):							
uires that the death certificate be executed signed by the attending physician and com- Health and Mernal Hygiene prior to burial, iws any Injury, or other traumatic er	RTIFICATION	CAUSE (Disease or Inju		C	/DD 40 4 00	NSEQUENCE			-					
Sertificating phy ygiene p	Ē	that initiated eventa resulting in death) LAS	т 📗	OUE 10	OH AS A CO	MSEQUENCE	JF):							i
ttend tal Hy	CER			d										
the dear y the att of Menta Injury.		PART II. Other significe	nt condition	a contributing to	deeth but i	not resulting	in the u	nderlyln	g ceuse c	given in i	Part i. 24a, W	AS AN AUTOPSY	24b.	WERE AUTOPSY FINDINGS
that the by the and any I	EDICAL	recent p									P	RFORMED?		AWAILABLE PRIOR TO COMPLETION OF CAUSE
signed Health		Tecent	meninc	MITTISA	JSLEO	poros	ISI	ASCI	(P,a)	nemi	La ¹□¹	ES 2 X NO		OF OEATH?
v require to the second to the	Σ	DID TOTAL COLO	OF 601 I	AID I I I I I I I I I I I I I I I I I I							[1 YES 2 NO
law las be Dept.	Z	DID TOBACCO U	-	KIBUTE TO CA			_			ERTAIN	1 🗆 📗			
OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with OIRECTOR: After this certificate has been signed by the attending physician and complete nours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremiten 28 is marked, or Item 28 shows any Injury, or other traumatic event,	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	28.	PLACE OF DE	OTHE							
CIAN: ertifica he St	X	1 YES 2 NO		1 Inpetient 2		nt 3 🗆 DOA			ne 5 🗆 Re	aldence	8 Other (Specia	1)		
PHYSIC this ce with ti	PHY	27. MANNER OF DEATH		28a. OATE OF (Month, D		28b. TI	ME OF		JURY AT DRK?		28d. DESCRIBE	HOW INJURY OC	CURED	
NG PHYS ther this sath with marked	BY		Pending Investigation				М		YES 2	NO				
NDING R. After r death		3 Suicide 8	Could not be	28a. PLACE C	F INJURY — atc. (Specify)	At home, ferm	street, fec	tory, offic	ie .		281. LOCATION (r or Rural Ro	oute Number,
CTOR: after	1	4 Homicide	determined		arer (opoony)						City or Town,	State)		
	COMPLE	29a. CERTIFIER 1 CERT	IFVING PHYSIC	CIAN: To the beat of	my knowledo	a death occur	and at the	time date		and do			S. I	
전 국가 모	Σ													and manner ea stated.
HOSPITAL FUNERAL WITHIN 72 P	8							opimon, c	T COUNTY	00 81 1110	time, date end pie	ce, and due to t	ria causo(a)	and marmer va stated.
THE HOSPITAL THE FUNERAL filed within 72 I	띪	29b. SIGNATURE AND TITLE	OF CERTIFIER	1/1/	/				29c. LICE	ENSE NUM		29d. OA	TE SIGNED	(Month, Day, Year)
TO THE HOSPIT TO THE FUNERA Be filed within 7 IMPORTANT: I	0	Northly	C. 1	oders the	M	1.			1	062	4-1		11-2	4-94
	- 1	30. NAME AND ADDRESS OF	11/1	COMPLETED CAD	SE OF DEATH	(ITEM 27) (Typ	e, Print)					.01	4.0	
	1	-POROTHY		OLZINOZ	774	203	SA	HIN	_5	-	SNOW	HILL A	B	21863
		31. DATE FILEO (Month, Day,		32. REGISTRA	R'S SIGNATU	RE						7		
	10	NOV 2	5 1994	32. REGISTRA	Danden	- Kandal	e.							
,				17										

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1. DECEDENT'S NAME (First, Middle, Last)		CENTIF	ICATE OF	DEATH	2. DATE C	REG. NO.			3. TIME OF DEATH
Burlie Thomas P					MONTH	DAY		YEAR	
		GE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE 0	18		994	5:40 PLACE (State or Forei
	№ 2 □ F	89 YRS.	MONTHS DAYS	HOURS MIN.	03-1	Day, Wear) 18-19(Country	ryland
9a. FACILITY NAME (If not institution, give stree	The second secon			OR LOCATION OF			9c. COUN	ITY OF D	EATH
Hartley Hall Nu RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	rsing Ho			noke Ci	ty_		Wo	rce	ster
Md. Worce	ster		TY, TOWN OR LOCA						10d. INSIDE CITY LIMITS? 1 X YES 2 NO
209 Laurel Str	eet		10	21851				S.	HAT COUNTRY?
	2. WAS DECEDENT EVI	ER IN U.S. ARMED	13. WAS DE	CENDENT OF HISP	ANIC ORIGIN?	(Specify Yes o	or No—	14. RACE	— American Indian, White, etc.
1 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 Y	PR DATES		pecify Cuban, Mexi S 2 NO Spec		can, etc.)		Specif	
15. DECEDENT'S EDUCAT (Specify only highest grade col	TION moleted)		S USUAL OCCUPAT		16b.	KIND OF BUSH	NESS/INDL	USTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	Ille. Do NOT u	use retired.)	wat or working					
6		Truck I	Driver			Eagle		1s	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S N		iddle, Maiden Si	urname)		
William Harvey Pays	ne			Sally	Carey				
John W. Payne				and Number or Rura Lee Cour					032
20a. METHOD OF DISPOSITION 1 (X Burla) 2 Cremetion 3 Remove		20b. PLACE AND DATE	OF DISPOSITION (A			20c. LOCA			
4 Donation 6 Other (Specify)		Ouinton C	Comot over		111/	Dog	A	0 01	tre Ma
		OUTHOUT C	remeret A			A PULI	OMOKE		LV , IVICI .
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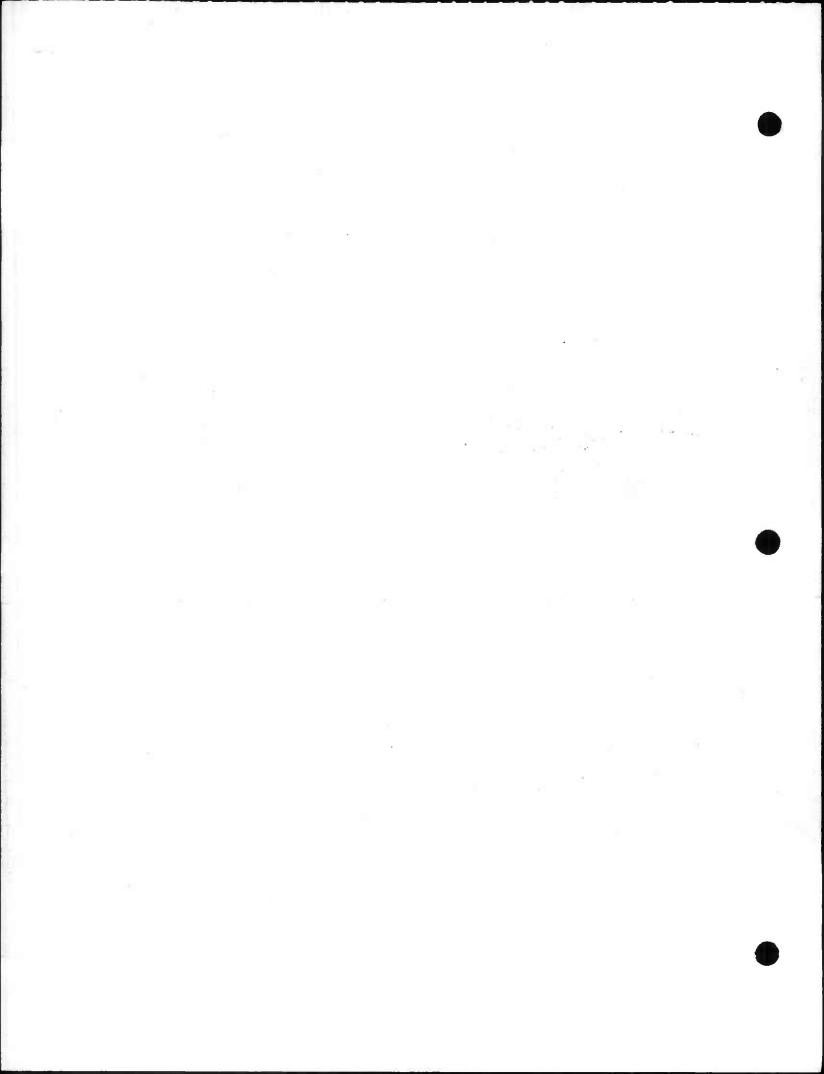
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

		TIEGIOTTATI			LITT	ICAIL	011	DEATI			EG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF	DEATH		YEAR :	. TIME OF DEATH
		CLARE	NCE WIN	FIELD	PARK	CER,	JR.		- 1	Nov.	7	199		11:50P M
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	last birthday)	IF UNDER 1 Y	EAR	IF UNDER 24	$\overline{}$	7. DATE OF	HTRIE			ACE (State or Foreign
		212 10 4147	1 M 2 F	7.2	YRS.	MONTHS D	AYS	HOURS	MIN.	(Month, De	y. Year)	- 1	Country)	
pino		213-18-4147 9e. FACILITY NAME (If not institution, give st	met end number)			9b. CITY, TO	WAL OF	L COATION	105.054		1/2		TY OF DEA	ryland
3 should	œ									AT IN				
ri .	2	4412 Preston H	ighway			Preston					Caroline			
S.	DIRECTOR	10e. STATE 10b. COUNTY			10c CIT	CITY, TOWN OR LOCATION						LAA MANDE SIEW		
200	<u>=</u>	Maryland C	aroline	100.0.	, , , , , , , , , , , , , , , , , , , ,	.ooniii			+		10d. INSIDE CITY LIMITS?			
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8	₹	CALL STREET, S					10f. 3	ZIP CODE						AT COUNTRY?
n. ansit	單	4412 Preston	Highway					216	655			Un	ited	States
physician. bunal-transit permit. Pages 1,	FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1			13. WAS	DECE	NDENT OF	HISPANI	C ORIGIN? (S	pecify Yes	or No-	14. RACE -	- American Indian,
		1 Never Merried 2 Merried	IF YES, GIVE W	AR OR DATES	JNO			2 W NO		, Puerlo Ricer	1, etc.)		Specify:	White, etc. Black
oding the	BY	3 Widowed 4 Divorced	W	WII				A						DIACK
r attending physician. use as the burial-trar	ED	15. DECEDENT'S EDUC (Specify only highest grade		16a.	DECEDENT'S	USUAL OCCU	PATION	N Lad umatica		16b. KJN	D OF BUS	INESS/IND	USTRY	
lor for u	垣	Elementary/Secondary (0-12)	College (1-4 or 5 +		ille. Do NOT us	se retired.)	ng most	or working						
spita hed	프		4	S	anita	ation				Wa	ste	Man	agem	ent
he hos detach once,	COMPL	17. FATHER'S NAME (First, Middle, Last)						18. MOTHE	R'S NAM	IE (First, Middl	e. Meiden S	Surneme)		
at o	S I	Clarence Lin	wood Ha	rris	Parke	r				ce Vi		,	Lohn	
bould ould	00	19e. INFORMANT'S NAME (Type/Print)				ADDRESS (SI	mot on							
retained by the hospital or 5 should be detached for unotified at once.	입	Anious Corene	Donlean											21655
y be			ratket						R II M	_				21655
leath. Page 6 may be funeral director, page xaminer must be		20e. METHOD OF DISPOSITION 1 ↑ Burlel 2 □ Cremetion 3 □ Remo	oval from State	cemetery.	cremetory or o	OF DISPOSITIO				DATE			City or Town	
ge 6 irect		4 Donation 5 Other (Specify)		Jo	hns (Cemet	ery	7		11-5	Pre	ston	, Ма	ryland
Para d		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE					ADDRESS						
hours after death. Page 6 may be ed in by the funeral director, page or removal. medical examiner must be		Framptom-Hawkins-Eskow Funera PO Box 43, Federalsburg, MD 2											al Home	
ns after of n by the removal.		22 PAST I Franch discourse				PO.	Вох	43	, F	edera	lsb	urg,	MD	
in b		23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between												
7		IMMEDIATE CAUSE (Finel												Onset and Death
within 24 npletely fills cremation,		disease or condition resulting in death) . ABOOMING CARLINGINGEDS - SITE UNKNOWN												Ino
ompletely fille 1, cremation, event, the	İ			OR AS A CONS										
	z													
	CERTIFICATION	Sequentielly list conditions, If any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):												
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h certifical anding phy Hygiene p	F	resulting in death) LAST	a.											!
the death certification in Mental Hygien	삥													
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signed by Health and										_ '''	_ TES 2	_ NO		F DEATH?
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SICIAN: The certificate h the State (1, or item)	ō	EXAMINER?	HOSPITAL:	26. PL	ACE OF DEA	OTHER:	one)							
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PHYSIC this ce with t	PHY	27. MANNER DF DEATN	28e. DATE OF (Month, Di		28b. TIM	E OF 28	c. INJUI			28d. DESCRI	BE HOW IN	JURY OCC	URED	
After this death with s marked	Ä	1 Natural 5 Pending 2 Accident Investigation				M 1	☐ YE	S 2 🗌 I	NO					
NDIN F: Aft		3 Suicide 8 Could not be	28e. PLACE O	F INJURY — At	home, term,	street, fectory,	office			281. LOCATIO	N (Street er	nd Number	or Rural Rou	ite Number,
afte afte	2	4 Homicide determined								City or io	wn, State)			
DR ATTEND DIRECTOR: J hours after Item 28 is	3	290. CERTIFIER 1 CERTIFYING PHYSIC	MAN: To the heat of	mu knowite de	doeth	and and all and	dec	and adv	1, 23/1		STATES	Politino		
HOSPITAL FUNERAL: within 72 t	COMPL	(Check only one) 2 MEDICAL EXAMINER												0.0000000000000000000000000000000000000
UNE	8	-	- On the besis of ex	annination end/c	A investigatio	m, in my opini	on, dea	in occursa	unt the ti	ime, alite end	place, enc	due to the	e ceuse(s) e	nd manner es stated.
TO THE HOSPIT TO THE FUNERA De filed within ?	ш	296. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENS	SE NUME	BER		29d. DATE	SIGNED (A	fonth, Day, Year)
E E E E	8	Williams						04	3au i			D ION	JOU 94	
	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH (IT	EM 27) (Type	Print)								
	I	WILLIAM J. CURRY	Mg 508	1005 NI	באם כע		East	400	CAM	2160	1			1
1				R'S SIGNATORIE							_			
	ı	31. DATE FILED (MO7/1). 09941)	Juna vai	rason-Ma	Marie									
E L			Ψ											



permit. iours after death. Page 6 may be retained by the hospital or attending physician. d in by the funeral director, page 5 should be detached for use as the burial-transit HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

Pages 1, 2, 3 should once. notified at Pe must medical examiner ysician and completely filled in by the prior to burial, cremation, or removal. the event, traumatic signed by the attending physician Health and Mental Hygiene prior to other 10 injury, any Shows t. of h certificate has been the State Dept. 23 Hem 0 marked, with w After DIRECTOR: Aff hours after dea item 28 is n

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Shana fuer MARTE 2:38 A. 12 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign DAYS 15 1 M 2 X F HOURS 213-41-6734 YRS. 10 Jan. 18, 1994 Maryland 9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR University of Maryland Baltimore Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b, COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Hagerstown 1 T YES 2 NO FUNERAL 10e, STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 427 N. Locust St., Apt. 1 21740 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, Whita, afc. FORCES? 1 YES 2. 1 X Never Married 2 Married If yes, specify Cuban, Maxican, Pu 1 TES 2 NO Specify: В Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 0 none 0 none 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Meiden Surname) Charles R. Pryor Karen Marie Loy BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Karen Marie Loy 427 N.Locust St., Apt. 1, Hagerstown, Md. 21740 20a. METHOD OF DISPOSITION
15 Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Cedar Lawn Memorial Park 12-7-94 4 Donation 5 Other (Specify) Hagerstown, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
MINNICH FUNERAL HOME RRRUCK 415 E. Wilson Blvd., Hagerstown, Md. 21740 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellura. List only one cause on each lina. Interval Batween IMMEDIATE CAUSE (Finsi Onset and Death disease or condition eumonic week resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Syncytial Virus 1 week iraton CERTIFICATION Sequentisity list conditions, if sny, leeding to immediate OUE TO (OR AS A CONSEQUENCE O cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in desth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS Heart disease: pulmonary win AWAILABLE PRIOR TO congenita COMPLETION OF CAUSE 1 YES 2 | NO DF DEATH? Microcephali 1 TYES 2 NO DID TOBACCO USÉ CONTRIBUTE TO CAUSE OF DEATH YES PHYSICIAN: NO T 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? SPITAL OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Rasidenca 6 - Other (Specify) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 28a. PLACE OF INJURY — Af home, farm, street, factory, offica building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED Could not be 4 Homicide TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT be filed within 72 hours at IMPORTANT; If Item 2 29a. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(e) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(a) and manner as stated. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE MO. 9

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

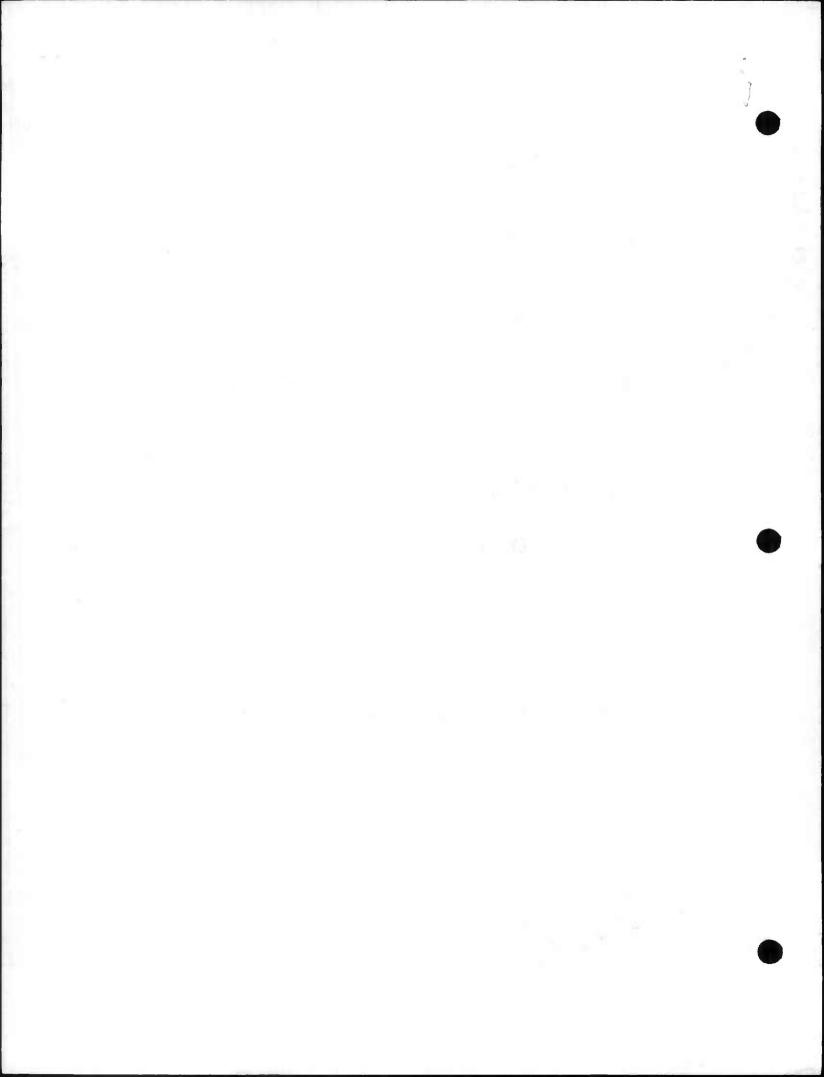
1994

University of mayland

32. REGISTRAR'S SIGNATURE

mo 2,301

22 S. Greene St.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and local persons and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 687604

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR				CERTIF	ICAT	E OF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Mid	dle, Last)								OF DEATH			3. TIME OF DEATH
H	Dolores Mae F	POSTER							No	v. 30	199	YEAR	11:10 A M
- 1	4. SOCIAL SECURITY NUMBER	5.	SEX 6	AGE (In yrs.	last birthday)	IF UNDE	R t YEAR	IF UNDER 24 HRS.		OF BIRTH		8. BIRTH	IPLACE (State or Foreign
	392-44-8368	1	□ M 2 🔀 F	62	YRS.	MONTHS	DAYS	HOURS MIN.		th, Day, Year) • 20 , 1 93	32	Mary	n) 7 1 and
	9e. FACILITY NAME (If not institut	ion, give street	and number)			9b. CIT	r, TOWN (OR LOCATION OF D		• 20,17.		NTY OF D	
DIRECTOR	Washington Co		Hospital			I	lage	rstown			Was	hing	gton
Ë	10e. STATE 10t	. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION					10d. INSIDE CITY LIMITS?
ᅙ	Maryland W	ashin	gton		Ha	igers	town	ı				_	1 X YES 2 NO
A	10e. STREET AND NUMBER						101	ZIP CODE			10g. CITI	ZEN OF Y	WHAT COUNTRY?
<u> </u>	958 Mt. Aetna	Road						21740				USA	A
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Mer 3 X Widowed 4 Divorced	Merried FORCES? 1 YES 2 X NO If yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, Whit If YES, GIVE WAR OR DATES 1 YES 2 X NO Specify: Specify:											
	15. DECEDE	NT'S EDUCATI	ON	160	DECEDENT'S	LISUAL	CCUPATIO	NA .	16	b. KIND OF BUS	INCO (INC	whi	.ce
Ë I	(Specify only high	hest grade con		200	(Give kind of life. Do NOT u.	work done	during mo	st of working	10	D. KIND OF BUS	ME22/IND	USIRT	
COMPLETED	9		0		cook					restau	ırant	:	
8	17. FATHER'S NAME (First, Middle	Lest)						18. MOTHER'S NA	ME (First,	Middle, Maiden	Sumeme)		
BEO	Clarence Theo	dore 1	Lininger					Alda 1	Key	Paden			
2	19e. INFORMANT'S NAME (Type/F							nd Number or Rural					
- 1	Barbara Kretz	er			930 M	lt. A	letna	Rd., Ha	ager	stown,	Md.	2174	10
	20a. METHOD OF DISPOSITION 1X Burlel 2 Cremetion 3 4 Donation 6 Other (Spe		from State	cemetery	cremetory or o	ther place			12-		CATION -		wn, State vn , Maryland
	21. SIGNATURE OF FUNERAL SE	RVICE LICENS	SEE					O ADDRESS OF FA			lager	300	in filar y Land
	· Sco	471	Me	nice	ch	·					gerst	own,	Md. 21740
	23. PART I. Enter the disea	ses, or com	plications that of	eused the	dasth. Do	not enter	the mo	de of dylng, suc	h ss ca	diec or respi	ratory err	eat,	Approximate
- 1	IMMEDIATE CAUSE (Final	Tollard. Elol											Intarvsi Batwean Onset and Daath
	disesse or condition reaulting in death)	Α.	Metasta	atic o	carcin	oma,	1ur	igs					8 weeks
	1-5-7-1-5-1-1-1-1-1-1				SEOUENCE O	,							
z	Sequentially list conditions	b	Squamou				ma,	vulva					12 months
Ĕ	if any, leading to immediate		DUE TO (O	R AS A CONS	SEOUENCE O	F):							
2	cause. Entar UNDERLYING CAUSE (Disease or Injury	c	DUE TO (O	B AS A CONS	SEOUENCE O	D.							
CERTIFICATION	that initiated events resulting in death) LAST	4	502 10 (0	n AS A CON	SECOLUCE O	r):							j i
		d											
	PART II. Other significant of			eath but no	t resulting	In the u	ndariyin	g causa given in	Part I.	24a. WAS AN PERFOR		24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DICAL	bilateral	pneumo	nia							1 TYES 2	**		COMPLETION OF CAUSE DF DEATH?
ME													t TES 2 NO
z	DID TOBACCO	USE CO	ONTRIBUTE	TO CA	USE O	F DEA	' HT	YES NO	O Ö				
PHYSICIAN: ME	25. WAS CASE REFERRED TO ME EXAMINER?		OSPITAL :			OTHE		ACE OF DEATH (Ch	eck only o	ne)			
Z N	t TYES 2 NO	,X	QSP1TAL: disputient 2 □ E		3 DOA			e 5 🗆 Residence	6 🗆 Oth	er (Specify)			
ᇤᆘ	27. MANNER OF DEATH 1 X Natural 5 Penc	tles	28e. OATE OF IN (Month, Day,	JURY Year)	28b. TIM	E OF	28c. INJ WO	URY AT	26d. DE	SCRIBE HOW II	NJURY OCC	CUREO	
à		etigation				M		YES 2 NO					
	3 Suicide 6 Coul	d not be	28e. PLACE OF I	NJURY At :. (Specify)	home, 1erm,	street, fec	tory, affic	•		CATION (Street e or Town, State)	nd Number	or Rural F	Route Number,
<u></u>													
COMPLETED			N: To the best of my										
ξ	2 MEDICAL	EXAMINER: 0	n the besis of exam	nination end/	or investigation	on, In my	opinion, d	eath occured at the	time, dat	e end place, en	d due to th	e ceuse(s	s) end menner se stated.
BE	29b. SIGNATURE AND TITLE OF	CERTIFIER						29c. LICENSE NUI	MBER		29d. DATI	E SIGNED	(Month, Day, Year)
		Jul.	100	ful.	A.			D21457			113	2/1/	/94
	30. NAME AND ADDRESS OF PER Abdul Wah	eed, M	D 12821	of DEATH (1 Oak H	тем 27) (Туре [ill A	. Print) Venu	e, H	agerstow	m, N	D 2174	0	1	
	31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S					-		,			
	DEC 0 2 1994	4	1 100										
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hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 that the death certificate be executed within Pages 1, 2, 3 should

permit.

funeral director, page 5 should be detached for use as the burial-transit

completely filled in by the

the attending physician and con Mental Hygiene prior to burial,

Health and

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TO THE HOSPITA
TO THE FUNERAL
De filed within 72
IMPORTANT: 19

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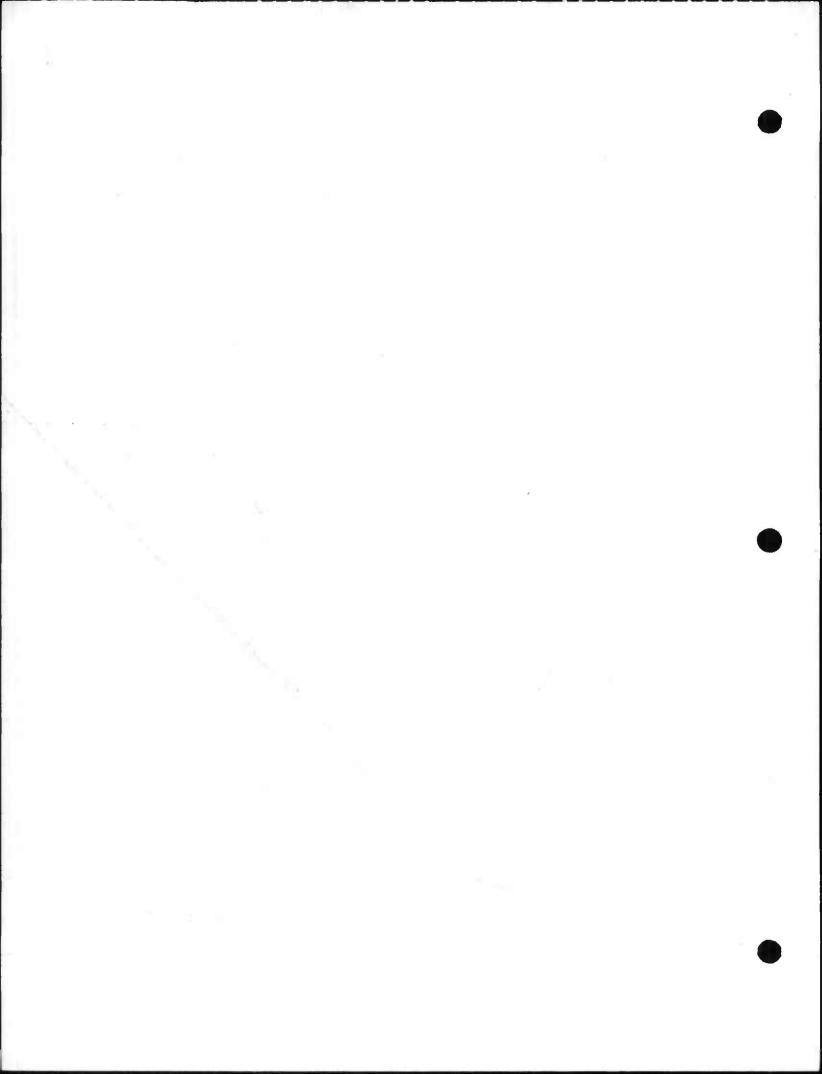
DIVISION OF VITAL RECORDS, P.O. BOX 68760, THE HOSPITAL DR ATTENDING PHYSICIAN: The law THE FUNERAL DIRECTOR: After this certificate has bo filed within 72 hours after death with the State Dept. IPORTANT: If item 28 is marked, or Item 23 is 1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 2105 ROGER EDWARD PEMBERTON 1/ 4. SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7 DATE OF BURTH 6. BIRTHPLACE (State or Foreign IF LINDER 24 MRS DAYS HOURS 1 🐼 M 2 🗌 F 577-26-1022 73 YRS. May 11, 1921 Oklahoma 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Washington County Hospital Hagerstown Washington 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Washington Hagerstown 1 K YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 911 Forest Drive 21742 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yee, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married ВY Specify: 3 Wildowed 4 Divorced W.W. II White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Telephone Company Supervisor 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Harold Edward Pemberton Dollie Simmons BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 21742 June D. Pemberton 911 Forest Drive Hagerstown, Maryland 20s. METHOD OF DISPOSITION
1

Burlel 2 □ Cremetion 3 □ Removal from State
4 □ DonetJon 6 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata Rest Haven Cemetery 12-2+1994 Hagerstown, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funeral Home 1331 Fastern Blvd. North Hagerstown, 23. PART I. Enter the diseases/or complications that eaused the death. Do not anter the mode of dying, such as cardiac or reapiratory arreat, shock, or hear failure. List only one cause on each line. Approximate IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE octa arrinoma 1 TYES 2 THO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER: 1 TES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF GEATH 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending м 1 YES 2 NO ВҮ Investigation Accident 28s. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide datarmined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE BE 29¢ LICENSE NUMBER 12915 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Medica 31. OATE FILEO (Month, i Denden-Renderl 1994



BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

1 - FOR STATE REGISTRAR		STATE OF MARYL			MENT OF H		MENTA	L HYGIEN	E		
1. DECEDENT'S NAME (First,	Middle, Last)	21 200					2. DAT	E OF DEATH	NY.	YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMB	USAN ,	Kodgers					- /1	127	190	14	1255 PM
219-36-9699		5 M	(In yrs. lest b		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	(Mon	eth, Day, Year)		Country	
9e, FACILITY NAME (If not in			5		CITY TOWN (OR LOCATION OF D		26, 1			nessee
Suburban		,			Beth		DEATH 9c. COUNTY OF DEATH Montgomery				
RESIDENCE OF DEC	EDENT						-		Mon	tgoi	mery
10a. STATE	10b. COUNTY				OWN OR LOCAT						10d. INSIDE CITY LIMITS?
Maryland	Monto	Jomery		Roc	kville						1 TES 2 TONO
Contract to the second	Farmland	Drive			101	. ZIP CODE					/HAT COUNTRY?
11. MARITAL STATUS		. WAS DECEDENT EVER I	NUS ARMI	FD	13 WAS OFC	20852 ENDENT OF HISPAI	NIC OBIG	N2 (Encelly Yea			States - American Indian,
1 Never Married 2 🔯	Merried	FORCES? 1 YES	2 X NO		If yes, sp	cify Cuben, Mexica 2 X NO Specif	in, Puerto	Ricen, etc.)	Of NO	Black	, White, etc.
3 Widowed 4 Divo	rced				1 123	Z MO Specif	у.			Spech	White
15. DEC (Specify only	EDENT'S EDUCATI	ION npleted)	(Give	kind of work	UAL OCCUPATION done during mo		16	b. KIND OF BUS	SINESS/INDU	STRY	
Elementary/Secondary (0	-12) C	College (1-4 or 5+)	life. D	o NOT use re	tired.)						
17. FATHER'S NAME (First, M)		4	Te	eacher				Educat			
Alban A.						18. MOTHER'S NA					
19e. INFORMANT'S NAME (7)			10h	MAILING AD	DRESS (Classes	Edna		Finley			
John C.			- 1								1 00000
20e. METHOD OF DISPOSITI	ON	201	PLACE AN	DDATEOFD	ISPOSITION (Ne	ne of 12/1/9	A DA		cation - cr		nd 20852
1 💢 Burlel 2 🗆 Crematio 4 🗆 Donetion 5 🗀 Other		000	rotary, Crattie	BLOLD OF OTHER	_{place)} ven Cei		4				g, Maryland
21. SIGNATURE OF FUNERAL	SERVICE LIGENS	SEE	200 0	I nea	22. NAME AN	D ADDRESS OF FA	CILITY	y Funoi			
* Meha	1 K.Y	Jegers		0846	Bethes	Chase, sda, Mary	ylan	d 208]	L4-350)1	Bethesda- n Avenue
23. PART . Enter the di	seases, or com	plications that cause t only one cause on a	the deet	h. Do not	enter the mo	de of dying, auc	h es cei	diec or respi	ratory arres	st,	Approximats
IMMEDIATE CAUSE (Fin		The same season have									Onset and Death
disease or condition resulting in death)	+	PNEUM	ONIA	9							/ week
		DUE TO (OR AS A	CONSEQU	ENCE OF):	A						
Sequentielly list conditi	ons. b	LHICDIA	CA	11168	51						6 days
if any, leading to immed ceuse, Enter UNDERLY		DUE TO (OR AS A	CONSECU		000	1000	THU	/			410.
CAUSE (Disease or Inju- that initieted events		DUE TO (OR AS A	CONSEQU	ENCE OF):	U) Men	LOPA	- 77 Y				Tyears
resulting in death) LAS	r										
DART II Other simulties	t conditions o				V = 10						
PART II. Other significe	nt conditions c	ontributing to deeth b	ut not res	sulting in ti	he underlying	csuse given in	Pert I.	24a. WAS AN . PERFOR		24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
		 .						1 YES 2	□ NO		OF DEATH?
DID TOPACCO U	CE CONTRIR	LITE TO CALIEF O	F DEAT	NEC .				1			1 YES 2 NO
DID TOBACCO US		UTE TO CAUSE O			Check only one)	UNCERTAII	И Ц				V-KOSS
EXAMINER? 1 YES 2 NO	H	OSPITAL:		01	THER:						
27, MANNER OF DEATH	- 1	28a, DATE OF INJURY		28b. TIME OF		5 Residence		er (Specify) SCRIBE HOW IN	LIURY OCCU	BED	
	Pending	(Month, Day, Year)		INJURY	M 1 □ Y	RK?				1120	}
a Coultida	Could not be	28e. PLACE OF INJURY	- At home	, farm, atras	t, factory, office		28f. LO	CATION (Street e	nd Number or	Rural R	oute Number,
	letermined	building, etc. (Spec	eny)				City	or Town, State)			
29a. CERTIFIER (Check only	FYING PHYSICIAN	: To the beat of my know	ledga, death	n occurred at	the time, date	end piece, and due	to the ce	use(a) and men	ner ea stated		
		in the basis of exemination									and manner ea atated.
29b. SIGNATURE AND TITLE						29c. LICENSE NUM		MO			(Month, Day, Year)
James	mus	try MD			1	DC 31/4	7/03	7678	> //	(,)	794
30. NAME AND ADDRESS OF	PERSON WHO CO	OMPLETED CAUSE OF DE	ATH (ITEM 2	27) (Type, Prin	1 0 1 1	,	/	0 0 0	- 11	Or C	3 / 1
31. DATE FILED (Month, Day,)	01 WES	JERN AVE	ATURE	W	ASNIN	MON!	70	700/	5		
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DIVISION OF VITAL RECORDS, P.O. BOX 687

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Thous a feer death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	ARTHUR ALEXAN	DER ROBLES			DECEMBER	12:40 рм			
	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	THPLACE (State or Foreign		
	124-56-1136	1 X M 2 🗆 F	19 YRS.			JULY 21,	1975 N	EW YORK	
<u></u>	9a. FACILITY NAME (If not institution, give si NIH, THE CLINICAL				R LOCATION OF DE		9c. COUNTY OF		
6	RESIDENCE OF DECEDENT	CENTER	1	BETHESDA	A, MARYLA	AND	MONTGOM	ERY	
DIRECTOR	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?	
	NEW YORK	KINGS	BROC	KLYN				1 TYES 2 NO	
FUNERAL	362 SO. 2ND. ST.			100	. ZIP CODE			WHAT COUNTRY?	
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	I U.S. ARMED			IC ORIGIN? (Specify Yes	USA nor No.— 14. BA	CE — American Indian.	
BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, sp		n, Puerto Rican, etc.)	Spe	ck, White, atc.	
				A		PUERTO F		PANIC	
ETE	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(Give kind of wor life. Do NOT use	rk done during mo	on st of working	166. KIND OF BU	SINESS/INDUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)		TUDENT			SCHOOL		
Š	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAM	ME (First, Middle, Maiden	Surname)		
BE (ALEJANDRO G ROBL	ES			CARMEN	E CIRILO			
2	19a. INFORMANT'S NAME (Type/Print)					loute Number, City or Tow	m, State, Zip Code)		
	CARMEN ROBLES 204_METHOD OF DISPOSITION	= [PLACE AND DATE OF	. 2ND.		OKLYN, NY	11211		
	1 Burial 2 Cremation 3 Remo	oval from State cem		DATE 20c. LOCATION — City or Town, Stata					
	21. SIGNATURE OF FUNERAL SERVICE LIC		DATIDUTE II.		ID ADDRESS OF FAC	1/	OHENO, I	18.7.8	
	N.N. Ch	mleus	M00091	W. W	. CHAMBEI	RS CO RI	VERDALE .	MD, 20737	
	23. PART i. Enter the diseases, or of shock, or heart fellure.	complications that caused List only one cause on e	the death. Do no	t enter the mo	de of dying, such	as cerdiec or reap	Iratory arrest,	Approximate interval Batween	
1	IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Car 210 Respiratory failure Due to (or as a consequence of):								
- 1	resulting in death)	DUE TO (OR AS A	CONSEQUENCE OF	atory	rails	re	a a	Naye	
z	Metastatic Ostessarcoma.								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate		CONSEQUENCE OF):				2 years		
ICA ICA	CAUSE (Disease or injury	C. OHE TO (OR AS A	CONSEQUENCE OF):						
Ē	that initieted events resulting in death) LAST		CONSEQUENCE OF):						
	DART II Other significant and district	o							
CAL	PART II. Other aignificant condition	e contributing to deeth b	ut not resulting in	the underlying	g ceuse given in i	PERFO	RMED?	Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
Ē						1 YES 2	≥ X NO	OF DEATH?	
Σ	DID TOBACCO USE	CONTRIBILITE TO	CALISE OF	DEATH V	ES NO			1 YES 2 NO	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		CAUSE OF		ACE OF DEATH (Che				
YSIC	1 YES 2 NO	HOSPITAL: 1 K Inputlent 2 ER/Outp		OTHER:	e 5 🗆 Rasidence	6 Other (Specify)			
F	27. MANNER OF DEATH 1 Natural 5 Pending	28a, DATE OF INJURY (Month, Day, Year)	28b. TIME	WO WO	RK?	28d. DESCRIBE HOW	NJURY OCCURED		
B	2 Accident Investigation	26s. PLACE OF INJURY	- At home form etc.		ES 2 NO	201 LOCATION (C)		100	
COMPLETED	3 Suicide 8 Could not be detarmined	building, atc. (Spec	ily)	eet, actory, one	·	28t, LOCATION (Street City or Town, State)	and Number of Hursi	Houte Number,	
PE	29a. CERTIFIER (Check only	CIAN: To the best of my know	edge, daath occurred	at the time, data	and place, and due	to the cause(a) and ma	nner as stated.		
NO.		R: On the basis of examination	and/or investigation,	In my opinion, d	eath occured at the	time, data and placa, ar	nd dua to the cause	(a) and manner as stated.	
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	1			29c. LICENSE NUM	BER	29d. DATE SIGNE	ED (Month, Day, Year)	
10	Agren Wager		_				▶ 12-1-	-94	
	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE			IF DIVE	BETHEED	MARVITA	MD 20000	
1	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN.	ATURE	TOOKV II	THE LIKE,	BETHESDA	, MARYLA	ND 20892	
	DEC 0 2 1994	Julia Davidson-1	andell.						

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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within chours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	* REGISTRAR CERTIFICA	TE OF DEATH	REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH	3. TIME OF DEATH
	FRANCIS Eugene RABBITT	Sr.	NOVEMBER 25	94 9:10 A M
		NDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	6. BIRTHPLACE (State or Foreign
	578-38-1621 1 M 2 DF 72 YRS. MONT	THE DAYS HOURS MIN.	(Month, Day, Year)	Washington, DC
	Se. FACILITY NAME (If not institution, give street end number) 9b.	CITY, TOWN OR LOCATION OF		BUNTY OF DEATH
E I	Defend looker (House &) en P	\a \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	D	` (
K	RESIDENCE OF DECEDENT	rescrip	11 1/2	~ (50 (h)
DIRECTOR		WN OR LOCATION		10d. INSIDE CITY
10	Prince George's On	LIMITS?		
	10e. STREET AND NUMBER	or Morlba	10a. Ci	ITIZEN OF WHAT COUNTRY?
FUNERAL	MTB Coount Dr.	Some	15	50
Z I		12 MMS DECEMBENT OF HIS	ANIC ORIGIN? (Specify Yes or No-	
	1 Never Merried 2 Married FORCES? 1 YES 2 NO	If yes, specify Cuban, Mexi	cen, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES	1 YES 2 NO Spe	offy:	Specify: Canara
<u></u>	15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUA	L OCCUPATION	16b. KIND OF BUSINESS/II	
COMPLETED	(Specify only highest grade completed) (Give kind of work d	one during most of working	TVS. KIND OF BUSINESSAI	TO STATE
PLI	12th N/A PBX Techni		Cap	Telephone Co.
M	17. FATHER'S NAME (First, Middle, Last)		IAME (First, Middle, Maiden Surname)	
BE	Harry Kemper Rabbitt 194, INFORMANT'S NAME (Kroe/Print)	Cathe		
2	The state of the s		I Route Number, City or Town, State, 2	
			Upper Marlbor	
	206_METHOD OF DISPOSITION 1. Warrier 2 Cremetion 3 Removal from State 206_PLACE AND DATE OF DIS 206_PLACE AND DATE OF	- City or Town, State		
е ,	4 Donetton 5 Other (Specify) Naryland Sta	8,1994 Chelten	ham, Maryland	
	21, SIGNATURE OF PUNERAL BENYOE LICENSEE	22. NAME AND ADDRESS OF	ACILITY Lee Funera	l Hame, Inc.
			andria Ferry R	
_	The Residence		20725	
	23. PART I. Enter the disesses, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, su	ch as cardisc or respiretory a	Approximate intervsi Between
	IMMEDIATE CAUSE (Finsi			Onset and Death
	disease or condition s. Rendered for the consequence of:	276		Indays
	DUE TO (OR AS A CONSEQUENCE OF):			
z	simusof ,			Col. 32 5
일	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):			
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury			
드	that initiated events DUE TO (OR AS A CONSEQUENCE OF):			
ᇤ	resulting in desth) LAST			1
	PARK II Ohan al-alfina Anadal			
EDICAL	PART II. Other significant conditions contributing to death but not resulting in the	underlying csuse given i	PERFORMED?	Y 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
8			1 YES 2 NO	OF DEATH?
ME				1 TYES 2 P NO
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES	□ NO □ UNCERTA	IN 🗆	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (CA			
Sic		HER: Nursing Home 5 - Residence	A C Other (Preside)	
Η	27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF	28c. INJURY AT	28d. DESCRIBE HOW INJURY O	CCUBED
	1 Netural 5 Pending (Month, Day, Year) INJURY	WORK?	Est. BEJONISE NOW INSOMY O	COONED
B	2 Accident Investigation 3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, street,		284 LOCATION (Standard Mark	0.10.11
□	3 Suicide 8 Could not be determined 226. PLACE OF INJURY — At home, farm, street, building, etc. (Specify)	tectory, office	28f. LOCATION (Street end Numb City or Town, State)	er or Hural Houte Number,
Ш		<u></u> -	<u></u>	
립	29e. CERTIFIER (Check only one)			
COMPL	2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in a	my opinion, death occured at the	e time, date end place, end due to	the ceuse(s) end menner es stated.
Ш	29b. SIGNATURE AND TITLE OF CONTUETER	29c. LICENSE N	JMBER 29d. DA	ATE BIGNED (Month, Day, Year)
00	Ar all will and	7230	63	11/26/84
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Paid!)	1,00	W -	.40-0///
	River (8000 Acoustus	(shorp)		
	31. DATE FILED (Month, Day, Year) 32. REGISTRAN'S SIGNATURE	20 10 4. 1		
	31. DATE FILED (Month, Day, Year) 1994 32. REDISTRANT SIGNATURE MONDALE			
	110/10/10			

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THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2s hours after death. Page 6 may be retained by the hospital or requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	1. DECEDENT'S NAME (First,	Middle, Last)				10/11/		DEM		2. DATE OF DEATH			3. TIME OF DEATN
	Tiyette		Neal	7	F	0				MONTH DAY YEAR			
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday)					TAC				November 25 1994 5:3			5:31 p M PLACE (State or Foreign
	240-54-8955	The state of the s				MONTHS	DAYS	HOURS	94494	(Month, Day, Year) August 20,1935 North Card)
	Se. FACILITY NAME (If not in	estitution nim a				01 0170							
œ		-		±-1		96. CITY		OR LOCATI		ATN		UNTY OF DE	
일	Southern i		nd Hospi	ldI		<u> </u>	C.	Linto	n		Pri	ince (George's
띭	10e. STATE	10b. COUNTY	1		10c. CIT	Y, TOWN C	OR LOCAT	TION					10d. INSIDE CITY
DIRECTOR	Maryland	Princ	e George	's			Clir	nton					LIMITS?
7	10e. STREET AND NUMBER						10	f. ZIP COD	E		10g, CI		NAT COUNTRY?
BY FUNERAL	11603 Zare	th Dri	ve						2073	5		U.S.F	
3	11. MARITAL STATUS		12. WAS DECEDEN	IT EVER IN U.S.	ARMED	13.	WAS DEC	ENDENT (IC ORIGIN? (Specify Yes	or No-		
	1 Never Married 2		FORCES? 1	YES 2	X NO		II yes, sp	ecity Cube	n, Mexican	i, Puerto Rican, etc.)			— American Indian, White, etc.
	3 Widowed 4 Divo	rced					1 1 123	2 N7 140	эреспу.			Afric	can Americar
B		EDENT'S EDU		18 e.	DECEDENT'S					16b. KIND OF BU	SINESS/IN		
E I	Elementary/Secondary (0		College (1-4 or 5	+)	(Give kind of life. Do NOT u	work done se retired.)	auring mo	ost of working	70				
I de	12th		4		Chief	Acco	unta	int		U.	S. 0	Govern	ment
COMPLETED	17. FATNER'S NAME (First, M	iddle, Last)						18. MOT	NER'S NAM	AE (First, Middle, Malden	Surname)		
BE (Bert	Nea	1					M	inni	e Glov	ær		
01	19e. INFORMANT'S NAME (7				19b. MAILING	ADDRESS	S (Street e	and Number	or Rural A	loute Number, City or Tow	n, State, Zi	ip Code)	
۴	Harold L. 1	Rogers		1160	1160	3 Za	reth	n Dri	ve C	linton, Ma	ryla	and 20	735
	20e. METHOD OF DISPOSITI	ION	mond from State	20b. PLA	CEANDDATE	OF DISPOS	SITION (Na	ame of N	ovem	DEMATES (20c. LO	CATION -	- City or Tow	rn, State
4 □ Donatton 5 □ Other (Specify) Garolina Biblical Gardens 1994 Nort							orth Carolina						
	21. SIGNATURE OF FUNERAL SERVICE OCCUPIED. 22. NAME AND ADDRESS OF FACILITY Lee Funeral Ho							Home	e, Inc.				
	11/11	11	UHS.	1/2		6	633	Old .	Alex	andria Fer	ry F	≀d Cli	inton, Md
	23. PARTI. Enter the di	iseases, or o	omplications the	it caused tha	daath, Do	not antar	tha mo	de of dv	lng, auch	as cardiac or read	retory as	reat	Approximate
	shock, or h	aart failure.	List only one car	use on each	lina.							1041	Interval Between
	IMMEDIATE CAUSE (Fin disease or condition	nal	D4 i	o ton	Tole	, 0	Dre	ast	\	anter			Onsat and Dasth
1	reaulting in death)		DUE TO	(OR AS A CON						201000-			
_				,		. ,.							
CERTIFICATION	Sequentially list conditi		DUE TO	(OR AS A CON	SEOUENCE O	F):							+
CAT	cause. Enter UNDERLYI	NG											
Ĕ	CAUSE (Disesse or Inju that initiated events		DUE TO	(OR AS A CON	ISEOUENCE O	F):							
H	resulting in death) LAS	T .	d										
	PART II. Other significa	nt condition	e contributing to	dooth but n	-0	In the con	4 1 - 1 -						
MEDICAL		1sel		wer	or readiting	in tha un	idariyin	g cause (given in i	Part I. 24a. WAS AN PERFOR		1	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
		TAN	Conco	mer				1 □ YES 2					COMPLETION DF CAUSE OF DEATH?
	DID TOPACCO	VICE C	CNITRIBUTE	TO 64	UCE OF	DEAT	711 14		110	_		'	1 TYES 2 NO
A N	DID TOBACCO		ONIKIBUTE	10 CA	USE OF	DEAI			NO				
PHYSICIAN:	EXAMINER?	O MEDICAL	HOSPITAL:	200 -		OTHER		LACE OF D	EATN (Che	ck only one)			
Ι×S	1 YES 2 NO		4	ER/Outpetlen			_		sidence (Other (Specify)			
	1.4	Pending	28a. DATE OF (Month, D		28b. TIM	IE OF JURY		PRK?	.	28d. DEŞCRIBE NOW I	NJURY OC	CURED	
B	2 Accident	Investigation				М		YES 2	NO				
		Could not be determined	building,	of INJURY — At atc. (Specify)	t home, ferm,	street, fect	ory, offic	•		28f. LOCATION (Street a City or Town, State)	and Numbe	ir or Rural Ro	oute Number,
절										to the cause(s) end mar			
COMPL	2 MEDI	CAL EXAMINE	R: On the besis of e	xemination end	or investigation	on, in my o	pinion, d	leath occur	red at the t	lime, date end place, en	d due to f	he cause(s)	end manner es stated.
w II	29b. SIGNATURE AND TITLY	ON CENTIFIER	OA					29c. LICI	NSE NUM	BER	29d. DA	TE SIGNED	Month, Day, Year)
5 8	10//	Na	DOWN !					DI	760	20	► 17	426	194
1	30. NAME AND ADDRESS OF	PERMON WH	COMPLETED CAU	SE OF DEATH (ITEM 27) (Type	, Print)	0	LIN	th.	1 1		-	
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/	31. DATE FILED (Month, Day, NOV 2	9"1994	32. REGISTRA	Paydsor	E Rando	202							
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/	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director	te filed within 72 hours after death with the State Dept. of Health and Mer	
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IAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writhin 24 h	etely 1	ematio	
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within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	director, page 5 should be detached for use as the burial-tr		
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		FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR	TMENT OF H	IEALTH AND						
Г		1. DECEDENT'S NAME (First, Middle, Last)		OLITII	ICATE OF	DEATH	2. DATE OF		3. TIME OF DEATH			
	1	BOBBY LEE R	REAVES				Nov.	24,1994	YEAR			
		The state of the s		In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF	BIRTH	6. BIRTHPLACE (State or Foreign Country)			
		1 20 00 10	X M 2 □ F 61	YRS.	MONTHS DAYS	HOURS MIN.	1-4-	33	Virginia			
-1,	,	9e. FACILITY NAME (If not institution, give street				OR LOCATION OF E			TY OF DEATH			
	<u> </u>	3516 Dunlap Stree	t		Temole I	Hills, M	laryland	d Princ	ce Georges			
	DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN DR LOCAT	TION			10d. INSIDE CITY			
			George	Ten	ple Hil				1 X YES 2 NO			
	M	3516 Dunlap Street			10.00	ZIP CODE			EN OF WHAT COUNTRY?			
	FUNERAL		2. WAS DECEDENT EVER IN	IIIS ARMED		0748	NIC DRIGINS /6	U.S.				
		1 Never Married 2 Married	FORCES? 1 YES	2 ND	If yes, sp	ecify Cuben, Maxic	an, Puerto Rica	n, atc.)	14. RACE — American Indian, Black, White, etc. Specify:			
	1 84	3 Widowed 4 Divorced				- X			Afro-American			
		15. DECEDENT'S EDUCATI (Specify only highest grade con	iON hpleted)		USUAL OCCUPATION work done during mo		16b, Kif	OF BUSINESS/INDU	STRY			
	7	Elementary/Secondary (0-12) c	College (1-4 or 5+)		,		Co	and Com	Cod Count			
nce.	COMPLEIED	17. FATHER'S NAME (First, Middle, Leat)	эрестат	Office			ie, Maiden Surname)	ice(Fed.Govnt.				
at C	DE C	Granville Reaves				Hattie		,				
E E	0	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rura		mber, City or Town, State, Zip Code)				
6 1	-	Bernice A. Reaves 3516 Dunlap Street Temple Hills, Md. 20748										
1 1 X Burial 2 Cremation 3 Ramoval from State Cametery crematory or other place							Suitland, Maryland					
E		4 Donation 5 Other (Specify)		shingtor		AL CEMET		Suitland,	Maryland			
amin		NT DM.	.0.00.		Mars	shall's	Funeral	l Home ad S uitl ar				
<u>sa</u>	\dashv	23 PADY Enter the diseases or same	thall	Ab death De-	4308	3 Suitl	and Roa	ad Suitlar	nd, Md.			
medi		23. PART/I. Enter the diseases, or complicatione that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate and the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, and proximate and the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, and proximate and the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, and the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, and the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, and the diseases, and the diseases are diseases and the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, and the disease are diseases and the disease are diseases.										
the last		IMMEDIATE CAUSE (Final disease or condition	ADENOCARCT	NOMA OF	THE PROS	TATE.	TV	Onset and Dea				
vent,		disease or condition resulting in death) a. ADENOCARCINOMA OF THE PROSTATE STAGE IV Due to (or as a consequence of):										
100	2	Sequentially list conditions, b.										
r other traumatic	≟ ∥	If any, leading to immediata cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE DE	ን :							
in the	2	CAUSE (Disease Dr Injury C	DUE TO (OR AS A	CONSEQUENCE DE	٦:							
to of		that initiated eventa resulting in death) LAST			r				į			
- I L	. 11	DART II Other sheelfleast conditions contribute to death and										
ws any inj	3	PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY PERFORMED?										
\$ 100 E							10	TYES 2X NO	OF DEATH?			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN S. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 [XNO 1 Inpetiant 2 ER/Outpatient 3 DOA 4 Nursing Home 5 [XResidence 6 Other (Specify)]							1 TYES 2 NO					
							IRED					
is marked,	2 Accident Investigation " 1 TES 2 NO											
ee U 4 Homicide determined						r nural moute Number,						
29a. CERTIFIER 1 CERTIFYING PHYSICIAN. To the heat of The heat of												
= 3), cause(a) end manner as stated,			
RTANT		29b. SIGNATURE AND TITLE OF CURPED	0			29c. LICENSE NU			SIGNED (Month, Day, Year)			
AMPORTANT:	a	(e)	Se0 40			D 14730			-25-1994			
X.	-	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEA	TH (ITEM 27) (Type,	Print)	D 17/30			. 23 1777			

TO BE COMPLETED BY FUNERAL DIRECTOR

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

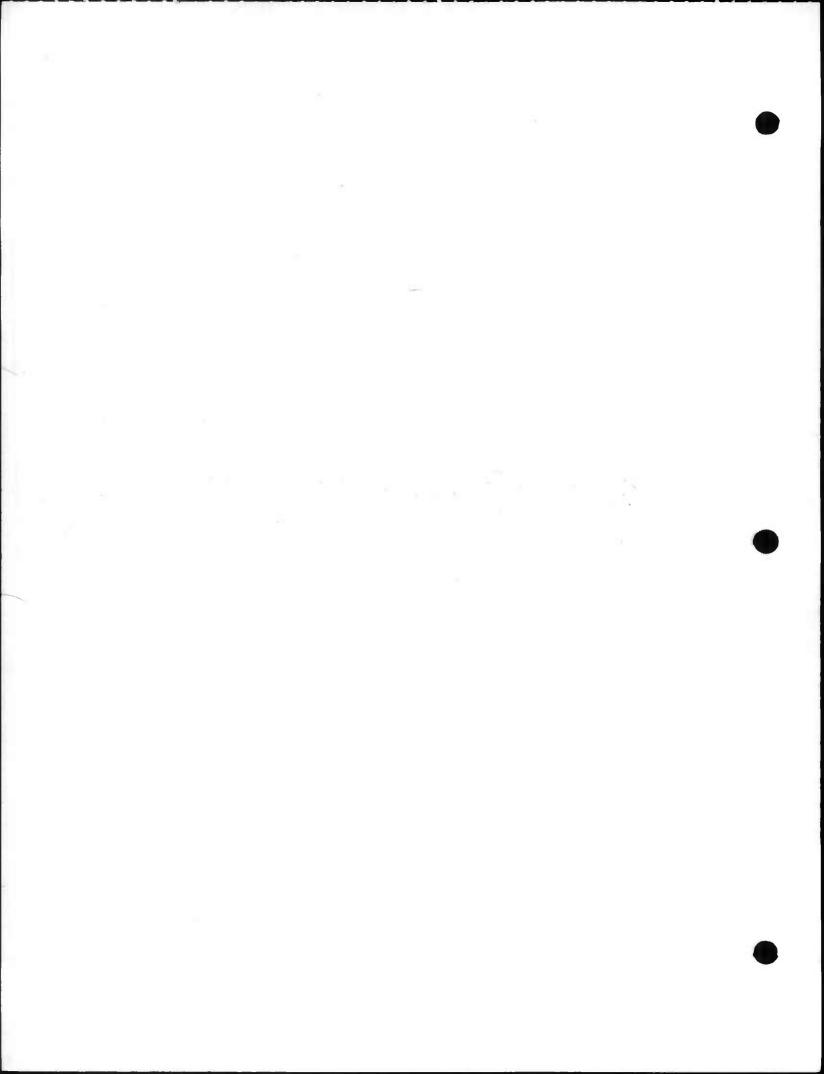
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

A+A O Mosky Ed 31. DATE FILED (Month, De), Year) DECO 2 1994

32' REGISTRAR'S SIGNATURE

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ITEM: 12. PER F	F.H. FILM	1 G-720 2/	3/95 t.t					74	J	1001	
1 - FOR STATE REGISTRAR		STATE OF M	IARYLAND /	DEPART ERTIFI	MENT OF H	IEALTH AND I	MENTAL HYGIEN				
1. DECEDENT'S NAME (First,							2. DATE OF DEATH			. TIME OF DEATH	н
DANIEL	STUART	r ricke	ER, SR.				Movember		YEAR QQ1	11:26	Рм
4. SOCIAL SECURITY NUMBI	ER :	5. SEX	6. AGE (In yrs. las	t birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		6. BIRTHPI	ACE (State or For	_
578-48-9359 9a. FACILITY NAME (If not ins		1 🔀 M 2 🗆 F	57	YRS.	MONTHS DAYS	HOURS MIN.	November 4, 1937 Maryland				
16806 Swanson S	Spur Road	_			Upper Me	or Location of De arlboro	EATH		ce Ge	orges	
RESIDENCE OF DEC	10b. COUNTY			I too CITY	TOWN OR LOCAT	TION					
Maryland Prince Georges Upper Marlboro										Od. INSIDE CITY LIMITS?	NO
16806 Swans	on Spui	r Road			101	20772		U.S.		AT COUNTRY?	
11. MARITAL STATUS		12. WAS DECEDEN	TEVER IN U.S. AB	MED			IIC ORIGIN? (Specify Yes	1	_	- American India Whita, etc.	n,
1 Never Married 2 X 3 Widowed 4 Divor	red	IF YES, GIVE W	IXIXYES 2 1250 AR OR DATES 58-SEPT.1		1 🗌 YES	ecify Cuban, Maxica 2 MO Specify	n, Puarto Rican, etc.)		Whit		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working											
Elementary/Secondary (0-		College (1-4 or 5+)		Employe	d	Retai	1 Sto	re		
17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname)											
Thomas Beall Ricker, Sr. Louise Erma Blake 19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									_		
Gail Ricker	,						ad, Upper			MD 2077	2
20s, METHOD OF OISPOSITION 1 LA Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) April 12/2/94 Washington, DC											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rendon/Hale Lanham Funeral Home											
· All	hand	1).	enel		9013 Ar	mapolis Ro	ed, Lanham,	MD 20	706		
23. PART I Enter the dis	seasea, or cor	mplications that	csused the de	sth. Do no	ot enter the mo	de of dying, sucl	n sa csrdisc or respi	ratory srre	st,	Approxima	
iMMEDIATE CAUSE (Final disease or condition		6	ina to		an	and				interval Be Onset and	
reaulting in death)	8.	DUE TO	OR AS A CONSEC	UENCE OF					-		
Sequentisily list condition	ons, b.		gn and	-	y Resta	ension	1	- 4			
if any, leading to immed cause. Enter UNDERLYIN	NG	Churn	is ch	060	Us of Zin	- Day	essali	Cis			
CAUSE (Disease or injur that initisted events	у 🔓 с.	DUE TO	OR AS A CONSEC	UENGE OF	1000	1 100	1			1	
reaulting in death) LAST	d	AThe	10-SC	leso.	sis H	eastal	ereali	····			
PART II. Other significan									24b. W	ERE AUTOPSY FIN	DINGS
						-5	PERFOR		A	WAILABLE PRIOR TO	0
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DID TOBACCO US		BUTE TO CAI	USE OF DEA	TH YES	□ NO □	UNCERTAIN	10		'	YES 2 N	۰
25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:	26. PLAC		(Check only one)						
1 TES 2 NO		☐ Inpatient 2 ☐	ER/Outpatient 3			e 5 🗆 Residence	6 Other (Specify)				
27. MANNER OF DEATH 1 Netural 5 P		28a. DATE OF (Month, Da		28b. TIME INJU	RY WO	URY AT RK? YES 2 NO	28d. DESCRIBE HOW I	NJURY OCCU	JRED		
2 Deviates	nvestigation	28e. PLACE OF	FINJURY — At hor	ne, tarm, at			26t. LOCATION (Street &	and Number o	e Pural Pau	to Mumbas	
	could not be etermined	building, o	etc. (Specify)	,	and the state of t		City or Town, State)	ind Number C	r nurei nou	te Number,	- 1
							to the cause(s) and mer				
		C. the basis of all	and and and of the		, my opinion, d		time, data and place, en	due to the	ceuse(a) a	nd manner aa sta	red.
296. SIGNATURE AND TITLE O	Well	1				29c. LICENSE NUM	BER	29d, DATE	SIGNED (M	onth, Day, Year)	
30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEATH (ITEM	1 27) (Type, I	Print)	1109	17	4	-/	14_	-
A+A O Mashu	Edi M	DP1	2305	110	NOVERT	Kun #	1. CHEEN	he 14	M	2021	0
31. DATE FILED (Month Day V	bar)	12 PEGISTRAS	P'S SIGNATURE	1711	VUVEK'	11~y #1	1. UNECIV	JE-11,	1100	~~//	



BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Tours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERT	IFICATI	E OF	DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE O	DEATH			3. TIME OF DEATH
-	JEFFREY	L. RUSSE	Table 1					MONTH DAY YEAR			
	4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthda	ly) IF UNDER			NOVE		30	94	11:50 A M
		tXXM 2 □ F	0.5	MONTHE	DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, I	Day, Year)		Count	HPLACE (State or Foreign ry)
	218-68-2892		25 YRS				JULY	10,	1969	WASI	HINGTON, DC
	9a. FACILITY NAME (If not institution, give s	,		9b. CITY	, TOWN O	R LOCATION OF DE	EATH		9c. COU	NTY OF D	DEATH
E	PRINCE GEORGE'S	HOSPITAL			CHEV	ERLY			PRI	VCE C	GEORGE'S
5	RESIDENCE OF DECEDENT										
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION										10d. INSIDE CITY
ੂ	MARYLAND PRIN	CE GEORGE'	S	МТ	тсне	LLVILLE					LIMITS?
	10e. STREET AND NUMBER			***		ZIP CODE			10a CIT	IZEN OF	WHAT COUNTRY?
œ l	1600 SUNDEW COU	DM					1		log. on		MINI COUNTRY
FUNERAL						2072				USA	
2	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EV FORCES? 1	ER IN U.S. ARMED	13.	WAS DECE	NDENT OF HISPAN city Cuben, Mexica	NC ORIGIN?	Specify Yea	or No-	14. RACI	E — American Indien, k, White, etc.
B	3 Widowed 4 Divorced	IF YES, GIVE WAR	R DATES			2 X NO Specify		att, 410.)			"BLACK
	5 Wildwar 4 Division			l							BLACK
ш	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDEN	T'S USUAL Of work done			16b. K	ND OF BUS	INESS/IN	DUSTRY	
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NO	Tuse retired.)	during mos	t or working					
ਕੂ ∣		1YR.	S7	UDENT	1			I	PVT.		
COMPLETED	17. FATHER'S NAME (First, Middle, Lest)					18. MOTHER'S NA	ME (First Min	dle Meiden	Sumamal	_	
	ERNEST G.	RUSSELI.			- 1		ETTY R				
H	19a. INFORMANT'S NAME (Type/Print)										
임					d Number or Rural I					00701	
	BETTY RUSSELL/ M	OTHER	1600	SUND	EW C	OURT MIT	CHELL	۱۸ ۲۲۰۲۰۱	i, MA	KYL!	AND 20721
	20a. METHOD OF DISPOSITION 1 X Buriel 2 ☐ Cremation 3 ☐ Remo	oval from State	TE OF DISPOS	ITION (Nan	ne of	DATE	20c. LO	CATION —	City or To	own, Siste	
	4 Donetion 5 Other (Specify)	MEMOR	DRIAL PARK 12-3 LANDOVER, MARYLAND								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY										
	J.B. JENKINS FUNERAL HOME 20785										
_	Madala	(/). N	Wy 101			LANDOVE					IARYLAND
	23. PART I. Enter the disease, prosphore, properties in the disease processes or condition resulting in death)	List only one ceuse of	on each line.	o not anter	the mod	ie of dying, suci	n ss cardie	c or reap	ratory sr	rest,	Approximate interval Between Onset and Death
		DUE TO (OR	AS A CONSEQUENCE	OF):							
-	_	A	1719								i i
CERTIFICATION	Sequentially list conditions,	DUE TO (OR	AS A CONSEQUENCE	OF):							<u> </u>
4	If sny, leading to immediate cause. Enter UNDERLYING			,							i 1
2	CAUSE (Disesse or Injury thet initiated events	DUE TO (OR	AS A CONSEQUENCE	OF):							
	resulting in death) LAST			J. 7.							i 1
_ 11	PART ii. Other significent condition	contributing to dee	th but not resulting	g in the un	derivina	ceuse given in	Pert I. 2	Is. WAS AN	ALITOPSY	24h	WERE AUTOPSY FINDINGS
5		- 12		70	, ,			PERFOR		1 -40	AVAILABLE PRIOR TO
EDICAL				_			1	YES 2	□ NO		COMPLETION OF CAUSE OF DEATH?
Ξ											1 _ YES 2 _ NO
ž I	DID TOBACCO USE CONTR	RIBUTE TO CAUSI	OF DEATH	YES 🔲 I	10 D	UNCERTAIN	4 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF D	EATH (Check	only one)						
5	1 TES 2 NO	HOSPITAL:	Outpetient 3 🗆 DOA	OTHER		5 Residence	8 Other /	(manihr)			
	27. MANNER OF DEATH	28e. DATE OF INJU		IME OF	28c. INJU	RY AT	28d. DESCE		JURY OC	CURED	
	1 Natural 5 Pending	(Month, Day, Ye	ar)	INJURY M	WOR	ES 2 NO					i i
הַ	2 Accident Investigation	28a PLACE OF IN	URY — At home, ferr	n otenal fact							
3 1	3 Suicide 8 Could not be 4 Homicide determined	building, etc.	Specify)	n, etrem, rect	ory, offica		City or	ON (Street a Town, State)	nd Number	or Rural F	Route Number,
로 [29a. CERTIFIER (Check only	CIAN: To the best of my k	nowledge, death occ	urred at the II	lme, deta a	and place, and due	to the cause	(a) and man	ner aa stel	led.	
ξ) and manner as stated
29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(e) and manner as stated.											
296. SIGNATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 29d. DATE SIGNED (Month) (Day, Year)											
	296. SIGNATURE AND TITLE OF CERTIFIER	di m. D		506adi m.D D1/327 12/1/90							
2	Joilan								29d. DAT	2	(Month/Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	DEATH (ITEM 27) (1)	rpe. Print)		D46	327		<u> </u>	12/	1199
20 20	30. NAME AND ADDRESS OF PERSON WHO		DEATH (ITEM 27) (7)	pe. Print) CHER		D46	327		<u> </u>	12/	Month/Day, Year) BELT MD 2077
2	30. NAME AND ADDRESS OF PERSON WHO TETWAN T SINC 31. DATE FILED (Month, Day, Year)	COMPLETED CAUSE OF CHAND	01 5917	CHER		D46	327		<u> </u>	12/	1199
	JS CLAZ 30. NAME AND ADDRESS OF PERSON WHO TETWANT SINC	COMPLETED CAUSE OF CHAND	DEATH (ITEM 27) (7) 1 59/7 CONTROL OF THE CONTROL	CHER		D46	327		<u> </u>	12/	1199

2. DATE OF OEATH DAY YEAR NOVEMber 28, 1994

BALTIMORE, MARYLAND 2121	y the hospital or att
MAR	e retained t
IMORE,	Page 6 may b
BALTI	s after death.
	STONE STA
,09	d within
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BOX 68760,	icate be executed within
P.O. BOX 68760,	th certificate be executed within
RDS, P.O. BOX 68760,	at the death certificate be executed within \$4. Jurs after death. Page 6 may be retained by the hospital or att

1 - FOR STATE REGISTRAR

JAMES

1. DECEDENT'S NAME (First, Middle, Last)

CHARLES

RING

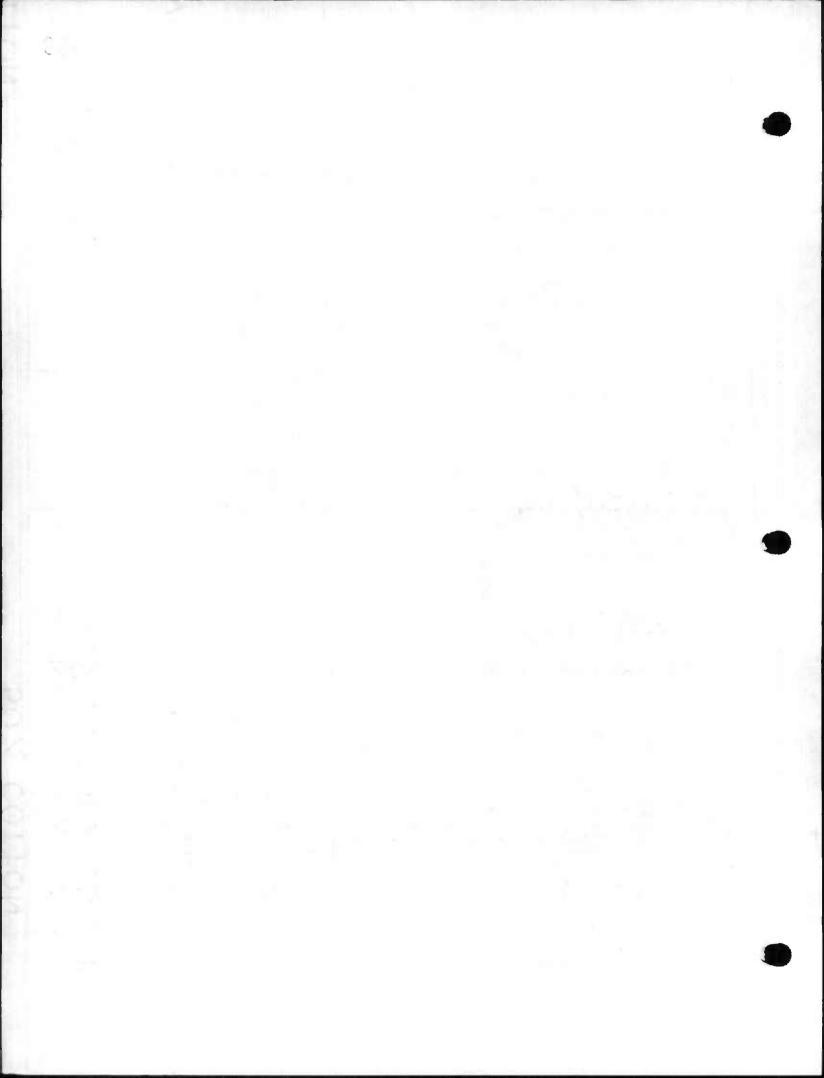
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68760,	
O. BOX 6876	
RECORDS, P.	
OF VITAL RI	
IVISION	

	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs, last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DA			7. DATE OF	ATE OF BIRTH 8. BIRT			ACE (State or Foreign		
	217-46-8401	1 ☑ M 2 ☐ F 48 YRS.		MONTHS DAYS HOURS MIN.			(Month, Day, Year)		1946	Cheverly, MD			
	Se. FACILITY NAME (If not institution, give street end number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. CDUNTY OF DEATH				
TOR	Prince George's		Cheverly					Prin	ce Ge	orge ts			
DIRECTOR	10e. STATE 10b. COUNT Maryland Princ	v e George	t s		ry, TOWN OR C		ION					130	d. INSIDE CITY LIMITS?
	10s. STREET AND NUMBER			1,5		-	ZIP CODE				10g. CITIZ		T COUNTRY?
FUNERAL	8150 Lakecrest D						0770				U.S.A.		
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 M Divorced	Never Married 2 Married FORCES? 1 X YE			S 2 NO If yes, specify Cuben, Mexican, Puert			, Puerto Ric	erto Rican, etc.) Black, White, et			American Indian, Thite, etc. White	
PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		+)	(Give kind of work done during most of working life. Do NOT use retired.)				16b KIND OF BUSINESS/INOUSTRY Construction					
BE COMPL	17. FATHER'S NAME (First, Middle, Last) Charles Francis	Ring		our pene			18. MOTHER			ldie, Maiden	Sumame)		
10 8	190. INFORMANT'S NAME (Type/Print) Charles Ring			100000	ADDRESS (S								2
	20a. METHOD OF OISPOSITION 1 Burlal 2 X Cremation 3 Ren	round from State	201	PLACE AND DAT	E DE DISPOS	ITION	(Name		DATE	200.10	CATION -		
d	4 Donalion 5 Other (Specify)		Me	cemetary, cremator etropoli	tan Ci	em	atory	12/	12/94	Ale	exandi	ia, V	/irginia
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE			Fra	nc:		sch'	s Son				P.A. MD 20781
CERTIFICATION	disease or condition resulting in death) Due to (or as a conseduence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Due to (or as a conseduence of): Due to (or as a conseduence of): Due to (or as a conseduence of):												
MEDICAL O	PART II. Other significant condition	In the unde	rlying	g cause giv	ven in P			N AUTOPSY RMED? 2 NO	CX OI	ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO			
PHYSICIAN:													
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 1 Inpatient 2 EX/Outpatient 3 DOA 4 Number Home 5 Residence 8 Other (Specify)										A C		
	27. MANNER DF OEATN 1 X Natural 5 Pending	ATN 28a. DATE DF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 5 Pending 28a. DATE DF INJURY 28b. TIME OF INJURY AT WORK? WORK?								TE/L			
TED BY	2 Accident 3 Suicide 6 Could not be determined 4 Homicide City or Town, State) 286. PLACE DF INJURY — At home, farm, street, factory, office building, atc. (Specify) 286. PLACE DF INJURY — At home, farm, street, factory, office City or Town, State)								te Number,				
COMPLETED	and any	SICIAN: To the best of											nd manner es stated.
BE CC	2 MEDICAL EXAMINER: On the beele of axamination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and man 29b. SIGNATURE AND TITLE OF CERTIFIED 29d. DATE SIGNED (Month, D.								fonth, Day, Year)				
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											10-14	
	Sukamaran C. Ary				reet,	Mt	. Rai	nier	r, MA	rylaı	nd 207	712-20)32
	31. DATE FILEO (Morrin, Day, Year) DECO 2, 1994	32. MEGISTI	AR'S SIGN	MUNEUL									-12/
	DEOU & 1001												

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

3. TIME OF OEATH

9:44 AM



TO THE HISPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

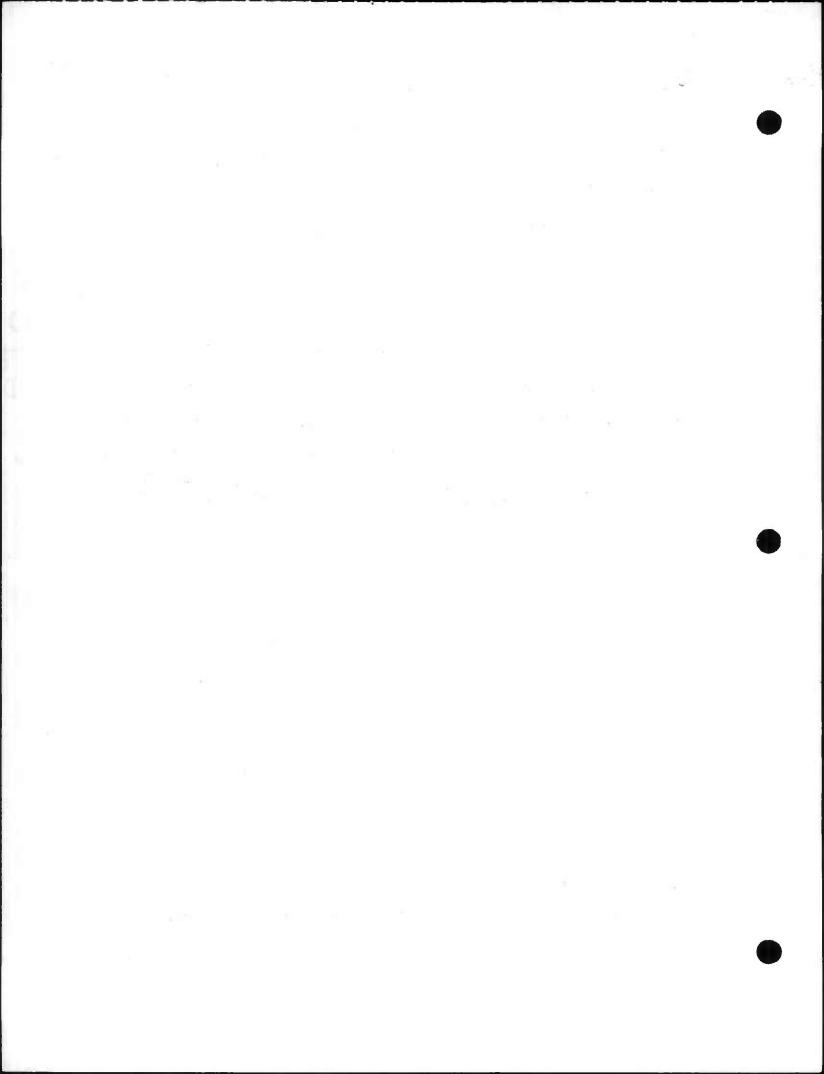
TO THE RUMERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

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RYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE						

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTA	L HYGIEN	E				
	1. DECEDENT'S NAME (First, Middle, Last) JAMES	MICHAEL		RAMBL	ER				YEAR	3. TIME OF DEAT	гн _{7\} м	
	4. SOCIAL SECURITY NUMBER 577–90–6425	SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. B							B. BIRTHP Country)	LACE (State or Fo		
OR	90. FACILITY NAME (If not institution, give st NORTH BOUND BEL		94	LANHA	R LOCATION OF D			9c. COUNT	Y OF DE			
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY		
FUNERAL DIS	Maryland Charles Waldorf								Y LIMITS?			
	6310 Panda Court 101. ZIP CODE 20603 102. CITIZEN OF W U.S.A											
В	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Nidowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 A NO	If yee, spe	ENDENT OF HISPA Incify Cuben, Mexico 2 1 NO Specif	an, Puerto		or No-	Black,	American Indi White, atc. White	en,	
LETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16e. DECEDENT'S US (Give kind of work life. Do NOT use re	done during mos stired.)	st of working	168	. KIND OF BUS		STRY			
COMPLET	12th 17. FATHER'S NAME (First, Middle, Last)		Floor Sander Flooring 16. MOTHER'S NAME (First, Middle, Maiden Surname)							-		
BE C	Daniel R. Rambl	er					. Leist					
TO B	19e. INFORMANT'S NAME (Type/Print)				nd Number or Rural	Route Num	ber, City or Town	r, State, Zip C				
	Gladys A. Latimer				., Wald					<u> </u>		
	206. METHOD OF DISPOSITION 1 Donation of Corporation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetary, crematory or other place) Cedar Hill Cemetery 12/3/94 Suitland, Maryland											
	21. SIGNATURE OF FUNERAL SERVICE LIG	Hale!		Geor		alas		uneral Home . Oxon Hill, Md.20745				
	IMMEDIATE CAUSE (Final	. MULTIPLE	ich lina.		de of dying, aud	ch as cen	diac or reapi	retory arre	at,	Approxim Interval B Onest and	etwean	
CERTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (DR AS A CONSEQUENCE OF):											
AL	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? 1 NYES 2 NO							4	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?			
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF	F DEATH YES	□ NO □	UNCERTAI	 N			1	YES 2 1	NO	
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF DEATH (Check only one)								
IXSI	1XIXES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Output	itlent 3 DOA 4	Nursing Home	5 - Reeldence				ENE			
ВУ Р	1 Motural 5 Pending Month, Day, Year) INJURY WORK?								HOU YOU	Total S		
	2 Accident Investigation 3 Suicide 6 Could not be determined City or Town, State) 28e. PLACE DF INJURY — At home, ferm, strest, fectory, office building, etc. (Specify) 28e. PLACE DF INJURY — At home, ferm, strest, fectory, office City or Town, State)											
COMPLETED		CIAN: To the best of my knowled: On the besie of exemination								and manner ee a	teted	
	200 SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month											
TO BE	Mayore The	Youll		O.C.M.E.					NOV 30, 1994			
	30. NAME AND ADDRESS OF PERSON WHO HAD ALL ALL ALL ALL ALL ALL ALL ALL ALL A	- KORWIL MO	111 Pe	enn St	reet, 1	Balt	imore	, Ma	ryla	and 21	201	
	DECO 2 1994	32. REGISTRAR'S PIGNA	don-Randall	2								





		1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIF	TMENT OF H	EALTH AND N	MENTAL HYGIEN				
		1. DECEDENT'S NAME (First, Middle, Lest) LESLIE	Р.		RANDOLPH		2. DATE OF DEATH DON'TH NOV. 7	3. TIME OF DEATH			
215-0020 attending physician. se as the burial-transit permit. Pages 1, 2, 3 should		4. SOCIAL SECURITY NUMBER 579–82–4896	5. SEX 6. AGE (In	yrs. Inst birthday) 33 YRS.	F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) June 8, 196	Cou	ITHPLACE (State or Foreign intry) TUCKY		
	TOR	90. FACILITY NAME (If not institution, give to 6099 APT. 7 MAJORS RESIDENCE OF DECEMENT				OR LOCATION OF DE	ATH	9c. COUNTY OF HOWARE			
	DIRECTOR	Mary and 106. COUNT	Howard	t0c. CIT	, TOWN OR LOCAT	Columb:	ia	10d. INSIDE CITY LIMITS? 1XX YES 2 \(\bigcap \) NO			
	FUNERAL	6099 Apt. 7 Majors				ZIP CODE		U.S.			
	BY	11 MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN I FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO		ecify Cuban, Maxicar	IC ORIGIN? (Specify Yes n, Puarto Rican, atc.)	Ble	ICE — American Indian, ack, White, etc.		
21 21 21 50 u	LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of v life. Do NOT us		st of working	166. KIND OF BUS	SINESS/INDUSTRY			
MARYLAND 2 retained by the hospital 5 should be detached for notified at once.	E COMPLET	17. FATHER'S NAME (First, Middle, Last) LYNWOOD P.	Sandolph	Accour	nt Executiv		ME (First, Middle, Maiden Judith Howa	Sumame)			
40 m	TO BE	190. INFORMANT'S NAME (Type/Print) Mr. Lynwood P. Rando					loute Number, City or Tow	n, State, Zip Code)	- · · · · · · · · · · · · · · · · · · ·		
BALTIMORE, ter death. Page 6 may be the funeral director, page wal.		Mr. Lynwood P. Randolph (Father) 3000 Fairhill Court Suitland, Maryland 20746 20e. METHOD OF DISPOSITION 1 (Name of cametery) 20 (Name of cameter) 20 (Nameter) 20 (Nameter) 20 (Nameter) 20 (Nameter) 20 (Nameter									
		22. NAME AND ADDRESS OF FACILITY ROllins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019									
ety filled in by nation, or remo		23. PART Enter the disesses, or shock, or heart feiture. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Complications that caused to List only one cause on each serious of the Complete Com	isorder	ot enter the mod	de of dying, such	n ss cardiac or respi	iratory srrest,	Approximats Interval Between Onset and Death		
ORDS, P.O. BOX 687(that the death certificate be executed that the attending physician and com th and Mental Hygiene prior to burial, any Injury, or other traumatic or	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.									
	MEDICAL C	PART II. Other significant condition	s contributing to death but	not reaulting i	n the underlying	g cause given in I	Part i. 24a. WAS AN PERFOR 1 X YES 2	RMED?	4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
VITAL REC JAN: The law requires rifficate has been sign the State Dept. of Heal or item 23 shows	1 1	DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	CONTRIBUTE TO	CAUSE OF	26. PL	ACE OF OEATH (Che	ck only one)				
NG PHYSICIAN: fler this certifica eath with the Su marked, or lit	PHYSICIAN	1XXYES 2 NO 27. MANNER OF DEATH t X Natural 5 Pending	1 Inpatient 2 ER/Outpat	lent 3 DOA	OF 28c. INJURY WO	RK?	6 Other (Specify) 28d. OESCRIBE HOW II	NJURY OCCUREO			
ON DING After death	red BY	2 Accident Investigation 3 Suicide 8 Could not be detarmined 4 Homicide detarmined M 1 YES 2 NO 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)							d Route Number,		
DIVISI HOSPITAL OR ATTEN FUNERAL DIRECTOR: within 72 hours after TANT: If item 28 i	COMPLET		CIAN: To the best of my knowled R: On the beels of exemination a						e(a) and manner as stated.		
TO THE HOSPITAL TO THE FUNERAL De filed within 72 i	86	2XX MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 295. BIGNATURE AND TITLE OF CERTIFIER 296. DATE SIGNED /Marrin On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. DATE SIGNED /Marrin On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. DATE SIGNED /Marrin On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
6	24	20. MAME AND ADDRESS OF PERSON WITH	O COMPLETED CAUSE OF DEAT	111 Pen	Street,	Baltimor	e, Maryland	21201			
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OB ATTENDING PHYSICIAN: The law requires that the clear certificate he executed within him after death. Page 6 may be retained to the hospital or attendion or health.

within tours after death, Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should	cremation, or removal.	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Ours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and o	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at a

	1 - STATE REGISTRAR	STATE OF MARYL		IENT OF HEALTH AN						
	1. DECEDENT'S NAME (First, Middle, Last)	JOHN ROY	ROBEY		2. DATE OF DEAT MONTH NOV. 16	DAY Y	3. TIME OF DEATH 2008 M			
	4. SOCIAL SECURITY NUMBER 213-01-4954	1 〒 75	YRS. MO		Month, Day, Ye	5,1919	BIRTHPLACE (State or Foreign Country) Maryland			
TOR	9a. FACILITY NAME (If not institution, give a Northwest Hospi RESIDENCE OF DECEDENT		91	Randallsto		Balti	of DEATH			
DIRECTOR	10a. STATE 10b. COUNT	imore County		Baltimore			10d. INSIDE CITY LIMITS? 1 YES 2 XXO			
FUNERAL	100. STREET AND NUMBER 8200 Dogwood Road			101. ZIP CODE 2.1.24	14	. 10g. CITIZEI	N OF WHAT COUNTRY?			
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IF YES, GIVE WAR OR D	DATES		ISPANIC ORIGIN? (Specil exican, Puerto Rican, at Specify:	ly Yes or No — 14	RACE — American Indian, Black, White, etc. Specify:			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION	16a. DECEDENT'S US (Give kind of work life. Do NOT use n	done during most of working tired.)		F BUSINESS/INDUS	TRY			
MP	9th 17. FATHER'S NAME (First, Middle, Last)		Pipefi			mbing				
	John A. Robey				S NAME (First, Middle, M.	elden Sumame)				
BE	19a. INFORMANT'S NAME (Type/Print)		195 MAILING AD	DRESS (Street and Number or I	ella Neal	y Braum State 7 in Cr	ordes .			
5	Ms. Hazel Robey			gwood Road,						
	20s. METHOD OF DISPOSITION	200	b. PLACEAND DATE OF			c. LOCATION — CIT				
	12 Buriel 2 Cremation 3 Rem	oval from State Cer	metery, crematory or other				t City, Marylan			
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE /	000 5:1901:	22. NAME AND AGORESS	OF FACILITY		CICA GULALS			
	Makemballer.	Sleck			meral Homs					
	23. PART I. Enter the diseeses, or	complications that cause	MO0535 d the death. Do not	enter the mode of dying.	City, Mar	respiratory arms	t, Approximata			
7	shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Interval Between Onset and Death								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
CERT	resulting in death) LAST	d								
MEDICAL	PART II. Other algnificent condition	as contributing to deeth i	but not reaulting in t	ha underlying ceuse give	PE	S AN AUTOPSY RFORMEO? ES 2 NO	24b. WERE AUTOPSY PINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PLACE OF OEATI	N (Check only one)					
YSI	1 TES 2 THO	1 Inpetient 2 ER/Out		Nursing Home 5 Asside	nce 6 Other (Specify)				
ву РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28d. DEŞCRIBE N	OW INJURY OCCU	RED						
	3 Suicide 9 Could not be 4 Homicide determined	26a. PLACE OF INJUR building, atc. (Sos	Y — At home, farm, stre- city)	rt, fectory, office	26f. LOCATION (S City or Town,		Rural Route Number,			
COMPLETED	annt.			t the time, date and place, and n my opinion, death occured a			ause(s) and manner as stated.			
TO BE	296. SIGNATURE AND TITLE OF CERTIFIE	The A	10	29c. LICENS	-522	29d. DATE S	NONED (Month, Day, Year)			
	30. NAME AND ADDRESS OF PERSON WH	solomon	4000	" Old Co	mt Ko					
	NOV 2 1 1994	32. BEGISTRAR'S SIGN	or Revelally							

al examiner mus	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must
r the funeral director, oval.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burifal, cremation, or removal.
fter death. Page 6 m	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with
BALTIMOF	DIVISION OF VITAL RECORDS, P.O. BOX 68760.

2

MATTHEW J.

31. DATE FILED (Month, Day, Year)

DFC 0 1 1994

	REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last)								REG. NO. 2. DATE OF DEATH MONTH DAY DAY VEAR 3. TIME OF				
	Teresa IV	1 Kobe	Y						//	1 2	29	94	10:20 A
ar .	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. Is	est birthday)	IF UNDER	DAYS	IF UNDER	24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		a. BIRTHP Country	LACE (State or Foreign
	213 - 74 - 2598	1 □ M 2 🙀 F	90	YRS.	WOWTHS	UAYS	HOURS	MITTEL.	May 1:		04		ington, DC
	9s. FACILITY NAME (If not institution, giv	e street and number)			9b. CITY	r, TOWN C	OR LOCATION	ON OF DE	EATH	1500	9c. COUN	TY OF DE	ATH
6	Charlestown Nurs	ing Cente	r		Cat	onsv	ille				Balt	imor	e
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COU			10c. CIT	y TOWN	OR LOCAT	TON						10d. INSIDE CITY
E C		timore				vill							LIMITS?
FUNERAL D	10e. STREET AND NUMBER	CIMOLC		1 00	CONO		. ZIP COD	F			10e CITIZ		HAT COUNTRY?
	700 Maidan Obaia						2122				USA		TAL COOK TATE
	709 Maiden Choic	e Lane	NT EVER IN U.S. A	RMED	12				NIC ORIGIN? (S	incelle. You o			- American Indian,
	1 Never Married 2 Married	FORCES?	MAR OR DATES			If yes, spi	ecity Cubs	n, Mexica	in, Pusrto Rics		-00 1	Black,	Whits, atc.
BY	3 🔀 Widowed 4 🗌 Divorced	IF YES, GIVE	MAN ON DATES			1 LI YES	2 X NO	Specify	у.			Specify	White
	15. DECEDENT'S El (Specify only highest gri		16a. D	ECEOENT'S	USUAL O	CCUPATIO	ON		16b, KII	ND OF BUSI	NESS/IND		
ų.	Elementary/Secondary (0-12)	College (1-4 or 5	+)	Give kind of le. Do NOT u	se retired.)	auring mo	st of working	ng					
MP	Grade 12		Hot	usewi	fe				Ow	n Hom	ne		
COMPLET	17. FATHER'S NAME (First, Middle, Last)						18. MOT	HER'S NA	ME (First, Midd	lle, Maiden St	umame)		
DE L	William Mueller						Cat	heri	ne Gos	sman			
2	19s. INFORMANT'S NAME (Type/Print)		1	96. MAILING	ADDRES	S (Street a	ind Number	r or Rural I	Aoute Number,	City or Town,	n, State, Zip Code)		
	William C. Barrows 10109 Colonial Drive, Ellicott City, MD									21042			
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of Disposition (Name of									City or Tow	n, Stats		
	4 Donation 5 Other (Specify) Ivy Hill Cemetery 12/3 Laurel, Mary									yland			
	Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707 23. PART I. Enter the disease, or complications that caused the death Do not enter the mode of diving such as cardiac or productions.												
	shock, or hear failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) a. CONGESTIVE NEART FAILURE DUE TO (OR AS A CONSEQUENCE OF):										Interval Between Onset and Dea		
CENTINGENION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): AURTIC INSURF ICI ENCY DUE TO (OR AS A CONSEQUENCE OF): d.												
MEDICAL CERTIFICATION	A SCITES PERFORMED? AMA										WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?		
	ATMAL FIBRILLATION 25. WAS CASE REFERRED TO MEDICAL								eck only one)				1 TYES 2 TAND
Σ	25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATH (Check only OTHER:					, , , , ,				
Σ	EXAMINER?	HOSPITAL:	ER/Outpatient	3 DOA				6 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED					
BY PHYSICIAN: MEDI		1 Inpatient 2		25b. TIN	IE OF JURY	28c, INJ WO	URY AT				JURY OCC	URED	

MADEN CHOICE LANE CATONSVILLE, MD 32. REGISTRAR'S SIGNATURE

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

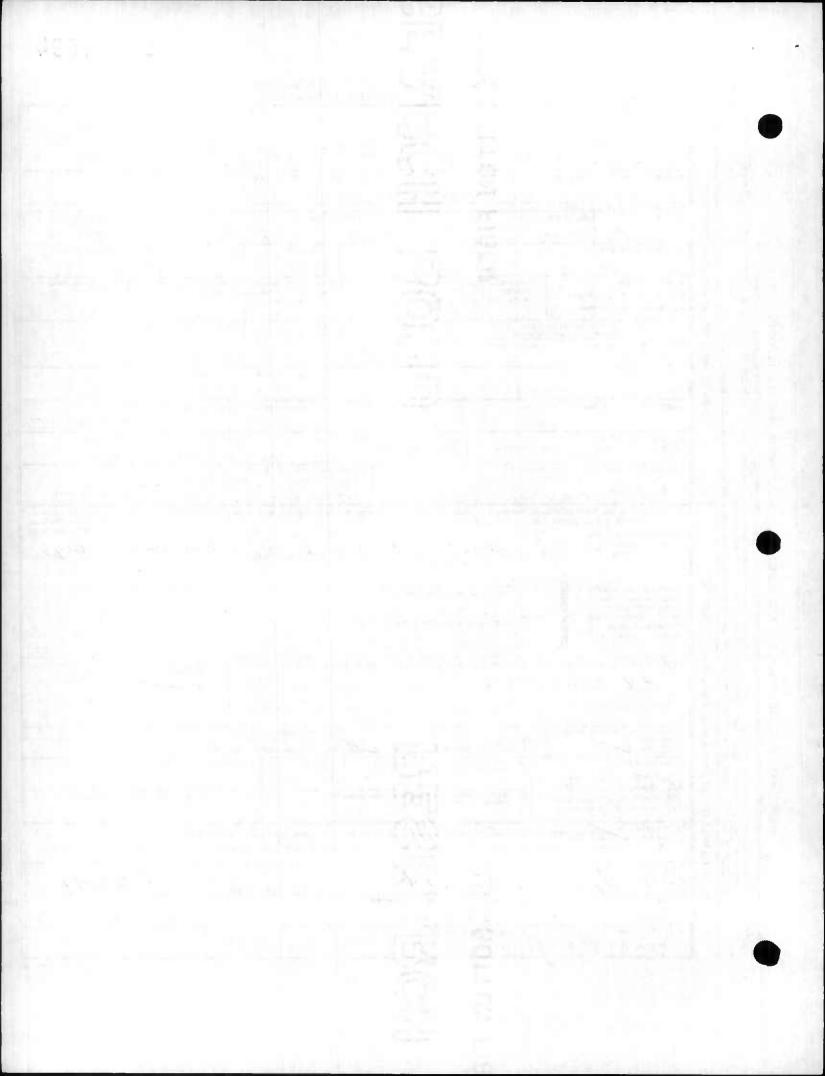
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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Nours after death. Page 6 may be retained by the hospital or attending physician.	
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1. DECEDEN	T'S NAME (First,	Middle, Last)	CERON F	ON REDMILES				2. DATE OF D MONTH NOVEME	3. TIME OF DEATH 8:30 a m				
705	- 05 -	2142		6. AGE (In yrs. 99	last birthday) YRS.		NYS HOURS	72	7. DATE OF BU (Month, Day Feb. (8. BIRT	HPLACE (State or Foreign try) ryland	
		sing &	Rehabil	itation	n Ctr.		umbia	TION OF DE	ATH	100	ward	DEATH	
10e. STATE Maryl	and	Howar				ry, town on L Lumbia	OCATION					10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
6334	Cedar I	Lane					2104			10g. C		WHAT COUNTRY?	
≥ 3 Widow	STATUS Married 2 1 1 ed 4 1 Divor		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2		If yo		an, Mexica	n, Puarto Rican.	ecify Yea or No , atc.)	Spe	E — American Indian, ok, White, atc. offy: White	
Elementa Grade 0 17. FATHER'S	(Specify only ry/Secondary (0-	DENT'S EDU- highest grade		+)	(Give kind of life. Do NOT u	work done durk work done durk me retired.)	PATION ig most of work	king		or Business/	NDUSTRY		
O 17. FATHER'S	NAME (First, Mic	idle, Last)					16. MO	THER'S NAI	ME (First, Middle	, Malden Surname)		
w John	Richard		niles						e Shor				
2	ANT'S NAME (Ty)									ity or Town, State,			
Milar	ed Zim							ton R				cyland 21227	
1 X Buriel	2 Cremation	3 🗆 Rem	oval from State	cemetery	crematory or i	OF DISPOSITION THE PROPERTY OF DISPOSITION OF DISPO		D - 1-		20c. LOCATION			
	on 6 Other		CEMSES	- I Mead	owrid		OCIAL			Dorsey	Mar	yland	
	6/1/	110	7//	///						ome, P.	Α.		
-	Java	they	complications the	ET.		313	Talb	ott A	ve. La	urel, M	aryla	and 20707	
if any, last cause. Ent CAUSE (DI that initiat	ily list condition ding to immed ler UNDERLYIN sease or injur ed events n death) LAST	late IG y	b DUE TO	(OR AS A CONS	SEOUENCE C	DF):							
WEDICAL CAL		eur +	a contributing to		t resulting	in the unda	rlying cause	given in		WAS AN AUTOPS PERFORMEO? YES 2- NO	24	b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
							E Second		T-Y				
25. WAS CAS EXAMINI 1 VES	E REFERRED TO	MEDICAL	HOSPITAL:			OTHEB	8. PLACE OF	DEATH (Che	eck only one)				
1 YES	3 2 110		1 Inpatient 2		_	4 Nursing		Residence	6 Other (Spe	ecify)			
Je minu	27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) Investigation						28b. TIME OF 28c. INJURY AT WORK? M 1 YES 2 NO			E HOW INJURY	INJURY OCCURED		
0 0 001-	0 _ 0	could not be etermined	28e. PLACE O building,	F INJURY — At atc. (Specify)	home, farm,	street, factory,	office		26f. LOCATION City or Tou	N (Street and Num vn, State)	ber or Rural	Floute Number,	
4 Horrista (Check o one)	nly CERTI		ICIAN: To the best of IR: On the bests of a									(a) and manner as stated.	
29b. SIGNAT	ORE AND TITLE	mic	CONT	SE OF DEATH (I	(TEM 27) (Typ	s, Print)	29c. LI	P 2	85	29d. 0	ATE SIGNE	0 (Month, pay, Year)	
B. Har	vey Mir	nchew,	MD 95		Annap		Road,	Suite	200,	Ellicot	t Cit	cy,MD 21042	
DE	C 0 1 19	994	Julia David	en-Rad-	11								



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

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:		1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.	
	1	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIM	E OF DEATH
		Tamsey Roberts 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE	1945 M
9		196-26-3804 1 M 2 1/F 82 YRS. MONTHS DAYS HOURS MIN. Feb. 1912 Country M	d.
3 should	æ	9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN	. 1141
s 1, 2,	DIRECTOR	RESIDENCE OF DECEDENT HOSPITAL BALTIMORE BALTIMO 100, STATE 1 100, COUNTY 100, CITY, TOWN OR LOCATION 100, STATE 1	
it. Pages	DIRE	Md talleat to and	NSIDE CITY MITS? YES 2 NO
it permit.	FUNERAL	100. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT CO	OUNTRY?
physician. burial-transit	N.	11. MARITAL STATUS 12. WAS DECEDENT EVER IN ON ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Year or No. 14. RACE - Am	eriçan indian,
fing phy the bur	BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced FORCES? 1 YES 2 NO Specify: If yes, specify Coan, Mexicen, Puarto Rican, stc.) Black, White Specify: Specify:	ack
use as	ETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	LEK
ospital o	COMPLE	Elementary/Secondary (0-12) College (1-4 or 5+) DOMESTIC PRIVATE FAM	:14
hours after death. Page 6 may be retained by the hospital or attending physician. ad in by the funeral director, page 5 should be detached for use as the bunial-tran or remonal. medical examiner must be notified at once.		17. FATHER'S NAME (First, Middle, Last) John Banks 16. MOTNER'S NAME (First, Middle, Maiden Surneme) Maggie Banks	
5 should	TO BE	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
page t		200 METHOD OF DISPOSITION 200 NETHOD OF DISPOSITION 200 PLACE AND DATE OF DISPOSITION (Name of DATE 200. ECCATION — City or Town, Star	262
director, p	9	4 Donallon 8 Other (Specify) Paradis Se Cemetery 12/3 Trappe Mc	1
after death. Page 6 m by the funeral director, imoval. Ilcal examiner must	*	HENRY FUNERAL HOME	41
d in by the or removal.			Appreximate
executed within 24 hours and completely filled in bunal, cremation, or re natic event, the med	ŀ	IMMEDIATE CAUSE (Finel	Interval Between
ompletely ompletely d, cremai		disease or condition resulting in death) a. Cutta Clebral Hemorling DUE TO (OR AS A CONSEQUENCE OF):	6 Days
ite be executed within 24 ysician and completely fille phor to bunal, cremation, traumatic event, the	NOI	Sequentially list conditions, b. To (or as a conscouence of):	pais
	ICATION	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	,
death certificate be e attending physician ental Hygiene prior to iry, or other traun	HTIFI	thet initieted eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST	
0 0 5	L CE	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 24s. WAS AN AUTOPSY 24b. WERE	AUTOPSY FINDINGS
s that the dea ned by the ati alth and Menta any injury,	EDICAL	PERFORMED? AMAILAI	BLE PRIOR TO ETION OF CAUSE
requires been sign of Heal shows	Σ		ES AZ NO
N: The law feate has be State Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one)	
PHYSICIAN: The law this certificate has with the State Depreted, or item 23	PHYSI	1 YES 2 NO 1 Pinpatlant 2 ER/Outpatlent 3 DOA 4 Nursing Name 5 Realdence 8 Other (Specify) 27. MANNER OF DEATN 28a. DATE OF INJURY 28b. TIME OF 26c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED	
After this death with marked	ВУ Р	1 Natural 5 Pending (Month, Day, Year) NJURY WORK? 2 Accident Investigation (Month Day, Year)	
TOR: after 28 is		3 Suicide 6 Could not be 4 Nomicide determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office City or Town, Stete) 28t. LOCATION (Street and Number or Rural Route	mber,
	(PLET	29a. CERTIFIER (Check only one) CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner ea stated.	
HOSPI FUNER Within	COMPL	MEDICAL EXAMINEH: On the basis of examination and/or investigation, in my opinion, death occursed at the time, date and place, and due to the cause(s) and much place and place and place and due to the cause(s) and much place and place and place and place and due to the cause(s) and much place and place an	
TO THE HOSPI TO THE FUNER be filed within IMPORTANT:	TO BE	Newsungery 66/4 11/28/9	Day, Year)
3	ř	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM)27) (Type, Print)	
		31. DATE FILED (Month, Day, Shar) 22 S. CTEONE St. Baltimore, M.D. 21201	
		NOV 3 0 1994 Seli Studio Rardall	2.5

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within colours after death. Page 6 may be retained by the In	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fined in by the funeral director, page 5 should be detained any within 72 hours after clearly with the State Deat of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
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id within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filiab in by the fired within 20 hours after clearly with the State Deat, of Health and Mental Hydiene prior to burial, cremation, or removal.	event,
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	FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTA	L HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH		3. TIME OF	DEATH	
	MARY	EVEL	YN	RING		Dec		1994	12:3	O AM	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE ('In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	8.1	BIRTNPLACE (State		
	212-01-4000 9e. FACILITY NAME (If not institution, give stre		85 YRS.	9b. CITY, TOWN C	R LOCATION OF DE	10/			farylar	ıd	
DIRECTOR	Sunshine RESIDENCE OF DECEDENT	Acres		N	orrisvi	llle		E	larford	1	
EC	10e, STATE 10b, COUNTY		10c. CITY	TOWN OR LOCAT	ION				10d. INSIDE		
	Maryland B	Baltimore		100	Baltin	nore	:	100 CITIZEN	1 TYES	2X NO	
FUNERAL		ers Forge	Road	1.00	21212)		log. dittaut	U.S.A.		
× I		12. WAS DECEDENT EVER II		13. WAS DEC	ENDENT OF NISPAN		1? (Specify Yes	or No — 14.	RACE — America		
BY FL	1 Never Merried 2 Merried 3 M Widowed 4 Divorced	FORCES? 1 YES	2 NO	If yes, sp	2 NO Specify	n, Puerto			Black, White, etc. Specify: AUCASI		
	15. DECEDENT'S EDUCA	ATION	16a. DECEDENT'S I	JSUAL OCCUPATION	PN	168	. KIND OF BU	SINESS/INDUST		all	
COMPLETED	(Specify only highest grade of Elementary/Secondery (0-12)	completed) College (1-4 or 5 +)	(Give kind of w life. Do NOT use	ork done during mo retired.)	st of working	1					
릴	12		Acc	ountan	t			Insur	rance		
S	17. FATHER'S NAME (First, Middle, Last)				18. MOTNER'S NA						
BE (Joseph E.	Garriga	n		Lill	Lie	J.	Tredv	vay		
10	19e. INFORMANT'S NAME (Type/Print)	_ =====================================	(1)		nd Number or Rural i				11	190	
-	George W. Trea				iew Dri	ive			1, Md.	21047	
	20a METHOD OF DISPOSITION 1 A Buriel 2 Cremetion 3 Remo 4 Donation 5 Other (Specify)	val from State	other place) estern	Cemete		12/		CATION - City	or Town, State	and free	
	21. SIGNATURE OF FUNERAL SERVICE LICE		CSUCIA		ID ADDRESS OF FA	_) <u>Da.</u>	r o x in O x	e, mai	YLam	
	> M. Gladel	in Kurt	T		rtz Fur rrettsv				nd		
	23. PART I. Enter the diseases, or co shock, or heert fellure. L	omplications that cause	d the deeth. Do n						, Appr	oximats	
	IMMEDIATE CAUSE (Finel	ist only one course on e	ech line.							ral Between t and Death	
	diseese or condition resulting in deeth)	LITT							16	mus	
		DUE TO (OR AS	CONSEQUENCE OF):		-					
NO.	Sequentially list conditions,		CONSEQUENCE OF								
CERTIFICATION	If sny, leeding to immediate cause, Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):							
E	CAUSE (Disease or injury that initiated events	DUE TO (OR AS /	CONSEQUENCE OF):					 		
E	resulting in deeth) LAST										
									1		
Ä	PART II. Other eignificent conditions	contributing to death b	out not resulting i	n the underlying	g cause given in	Part I.	24a. WAS AN		24b. WERE AUTO AVAILABLE 1	PRIOR TO	
ă							1 TYES	NO	COMPLETIO OF DEATH?	N OF CAUSE	
B									1 🗆 YES	2 NO	
ÿ											
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26, PI	ACE OF DEATN (Ch	eck only o	ne)				
ΥS	1 D YES 2 NO 27. MANNER OF DEATN	1 Inpetient 2 ER/Out			e 5 Residence						
古	1 Naturel 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIMI	JRY WO	RK?	28G. DE	SCHIBE HOW	INJURY OCCUR	EU		
B√	2 Accident Investigation 28s. PLACE OF INJURY — At home farm street, fectory, office 28s. I DCATIC							and Number or	Rural Boute Number		
3 Suicide 8 Could not be determined 296. PLACE OF INJUNY — At nome, term, street, sectory, office building, etc. (Specify)							281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
COMPLETED	enel enel	CIAN: To the best of my know									
8	A /	R: On the beele of examination	n end/or investigation	n, in my opinion, d	eath occured at the	time, det	e end place, e	nd due to the c	suse(e) end manne	r as steted.	
BE (29b. SIGNATURE AND TITLE OF CENTURES				29c. LICENSE NU	MBER	2,3	29d, DATE SI	GNED (Month, Day,	Year)	
0	10,100	2010		-W	10	4.59	43	10	1999		
	30. NAME AND ADDRESS OF PERSON WHO	S COMPLETED CAUSE OF DE	AIN (ITEM 27) (Type,	Fore	st Hi	1),	Md.	210)50		
	DEC 0 2 1994	REGISTRARIS SIGN	Radall			1					

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and of the second

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

		FOR 1 - STATE REGISTRAR	STATE OF MARYI		RTMENT OF H		MENTAL HYGIEN	E			
		1. DECEDENT'S NAME (First, Middle), Last ROLAND	Edward	Ruh	l, Jr.		2. DATE OF DEATH DATE NOV. 12	3. TIME OF DEATH 11:03A			
		4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		HPLACE (State or Foreign		
2		218-22-5441	1 🔀 M 2 🗆 F	67 YRS.	MONTHS DAYS	HOURS MIN,	5/6/1927	Coun	MD		
3 should	nc	90. FACILITY NAME (If not institution, given Memorial Hos)		ston		R LOCATION OF DE	НТА	9c. COUNTY OF Talb			
2,	СТОВ	RESIDENCE OF DECEDENT		SLOII	La			Talb	<u> </u>		
sage	DIREC	10a. STATE 10b. COU		10c, CI	Y, TOWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?		
mit. P		MD Ca	roline		Ridgely				₹∏ YES 2 □ NO		
burial-transit permit. Pages 1,	RAL	11 9th St			10f.	ZIP CODE			WHAT COUNTRY?		
al-tran	FUNER	11 9 CH SC	12. WAS DECEDENT EVER	IN U.S. ARMED	13. WAS DEC	21660 ENDENT OF HISPAN	IC ORIGIN? (Specify Yes	USA or No 14, RAC	CE — American Indian,		
buri.	BY F	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 TY YES	2 NO	It yea, spe		n, Puarto Rican, etc.)	Blac	ck, White, atc. CHYWhite		
as the		15. DECEDENT'S E	DUCATION	100 DECEDENTS	USUAL OCCUPATION			<u> </u>			
or use	ETE	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT L	work done during mos	st of working	18b. KIND OF BUS	SINESS/INDUSTRY			
thed fi	COMPL	11th		carp	enter		Baltimor	e Co. Bu	reau of Hwy		
detac	Ö	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Malden	Sumame)			
ed at	BE	Roland E. Ruhl,	Sr.				d Stavely				
5 should notified	임	Barbara Carol T	aeuher Ruhl				Number, City or Town				
page it be		20a. METHOD OF DISPOSITION	20	b. PLACE AND DATE	OF DISPOSITION (Na			CATION — City or 1			
must		1 X Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	imoval from Stata Cer	Moodlawn	Cemeter	У	11/16 Ea	ston, Ma	ryland		
tuneral di I. examiner		4 Donation 5 Other (Specify) Woodlawn Cemetery 11/16 Easton, Maryland 21. SIGNATURE OF FUMERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Fleegle-Helfenbein Funeral Home									
the fun val.		106 Sunset Ave., Box 160, Greenshore, MD									
ed in by the or remova medicai		23. PART I. Enter the diseases, part shock, or heart failur	or complications that cause re. List only one cause on a	ed the deeth. Do each line.	not enter the mod	de of dying, suct	es cerdiac or reepl	ratory errest,	Approximate interval Between		
the attending physician and completely filled in by the funeral director, page 5 should be detached for use Mental Hygiene prior to burial, cremation, or removal. nlury, or other traumatic event, the medical examiner must be notified at once.		immediate Cause (Finel disease or condition resulting in death) Due to (or as a consequence of):									
ompletely filled, cremation, event, the		resulting in death)	a. Chronic	A CONSEQUENCE O	nelive	Gundon	m deser		years		
d com unial, (z										
sician and c irior to buris traumatic	CATION	Sequentially list conditions, if sny, issding to immediate	DUE TO (OR AS	A CONSEQUENCE O	IF):						
physic ne prio	FICA	CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF):									
Hygier or oth	RTIFI	that initiated eventa resulting in death) LAST									
y the atte of Mental injury,	CEI	PART II. Other significent conditi	ings contribution to death	had and and dates	t- M d- d t		-U. T				
and h	CAL		+ Called			Juse given in	PERFOR	MED?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
signed Health a	EDIC	atrial arrhithmes Orelates 11 yes 2 100 COMPLETION OF CAU OF DEATH									
been sign pt. of Heal 3 shows	N.:	DID TOBACCO USE COR	ITRIBUTE TO CAUSE (OF DEATH Y	ES NO	UNCERTAIN			1 YES 2 NO		
certificate has been signed by it the State Dept. of Health and if, or Item 23 shows any in	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEA	TH (Check only one)						
the St	HYSI	1 TYES 2 THO 27. MANNER OF DEATH	4 Inpatient 2 - ER/Out		4 - Nursing Home	5 Residence					
After this c death with s marked,	<u> </u>	Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. Till IN	JURY 28c, INJUNY WOI	RK?	28d. DEŞCRIBE HOW II	NJURY OCCURED			
After death s ma	D BY	2 Accident Investigatio 3 Suicide 8 Could not t	28a. PLACE OF INJURY	Y — At home, ferm,			28t. LOCATION (Street a	ind Number or Rural	Route Number,		
s after	2	4 Homicide detarmined	building, atc. (Spe	вспу)		ĺ	City or Town, State)				
L DIRI	MPLE		YSICIAN: To the best of my know	wledge, death occur	ed at the time, data	and place, and due	to the cause(a) and man	ner as stated.			
thin 7	CON	one) 2 MEDICAL EXAM	INER: On the basis of examination	on and/or investigation	on, in my opinion, de	asth occured at the	time, data and placa, and	d due to the cause	(s) and manner as stated,		
TO THE FUNERAL DIRECTOR: After this be filed within 72 hours after death with IMPORTANT: If Item 28 is marked	BE (296. SIGNATURE AND TITLE OF CERTIF	ER			29c. LICENSE NUM	BER	29d. DATE SIGNE	D (Month, Day, Year)		
₽ 8 ₹	٥ ا	30, NAME AND ADDRÉSS OF PERSON V	WHO COMPLETED CAUSE OF DE	FATH (ITEM 27) /Xm	- Bring)	05919	7	11/13	2/90/		
		Dand 6.0/w	~ ~ 503	Outch	nun la	me tou	to us	2160/			
	ĺ	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	NATURE							
l		NOV 15 '94	Acha Savidron	Rando Do							

		1 - STATE REGISTRAR		STATE OF I	MARYL					DEAT DEAT		MENTA	REG. NO.	E			
		1. DECEDENT'S NAME (First, I		(NMN)			ROE	ERT:	3			2. DATE	Nov 2	1994	EAR 3.	TIME OF DEATH 6:00 am M	
10		4. SOCIAL SECURITY NUMBE 218-32-7076		5. SEX 1 M 2 F	6. AGE (1	In yrs. lest t	birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	(Mon	of BIRTH	1909	Country)	ACE (State or Foreign	
2, 3 should	CTOR	9a. FACILITY NAME (# not inst Saint Josep	h Hospi					96. CITY	_		ON OF DE	ATH		9c. COUNTY		Н	
	딥	RESIDENCE OF DECI	10b. COUNTY				10c. CIT	Y. TOWN	OBLOCAT	TION			-		140	4 Meine City	
permit. Pages 1.	- DIRE	Maryland		arford				., 10		Jop						d. INSIDE CITY LIMITS? YES 2 NO	
it per	FUNERAL	10s. STREET AND NUMBER	1						100	ZIP COD		_		10g. CITIZEI		T COUNTRY?	
trans	H	913 Pine Str		12. WAS DECEDER	IT EVEN IN	ALIIS ADMI	ED	149	WAS DEC		21085		AM (P) M - M -		USA		
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit notified at once.	B≺	1 Never Married 2 🔀 R	ferried	IF YES, GIVE WAR OR DATES 1 ☐ YES 2 ☑ NO Specify:						Black, Specify:			American Indien, Thite, atc. White				
21: atter	日		DENT'S EDUCA highest grade o			16e. DECE (G/ve	kind of v	vork done	CCUPATIO	ON st of workin	na	16	b. KIND OF BUS	INESS/INDUS	TRY		
AND 21 the hospital or detached for u once.	COMPLET	Elementary/Secondary (0-1	12)	College (1-4 or 5	+)	life. D	o NOT us	retired.)					Rul	bber M	anuf	acturing	
AN the hos detach	Ö	17. FATHER'S NAME (First, Mid	ldle, Last)							18. MOT	HER'S NAP	ME (First,	Middle, Meiden	Sumame)			
H by	BE (Henderson (n		iley								•	nmn) Bailey				
E, MAR by be retained bage 5 should be notified	5										21085						
ORE e 6 may ector, pa										cation - cm	or Town, West	state Virginia					
BALTIMORE, after death. Page 6 may be ay the funeral director, page moval. cal examiner must be		* Steph	22. NAME AND ADDRESS OF FACILITY HOWARD K. McComas III Funeral 1317 Cokesbury Road, Abingdon						Hom Md	e, P.A.							
hours of re		23. PART I. Enter the dis shock, or ha IMMEDIATE CAUSE (Fine disease or condition	ert fallure. Li ni	et only ona cau	use on e	ech line.				de of dy	ing, such	as car	diac or respi	ratory arrea	,	Approximate Interval Between Onset and Death	
68760, executed within 24 and completely fille o burial, cremation, natic event, the		resulting in deeth)	• 0.	CORON DUE TO		CONSEQU			E					<u></u>		YEARS	
OX 687(e be executed sician and common to bunial, traumatic en	ATION	Sequentially list condition if any, leading to immediate	ate	CONGE		CONSEQU			E						0.0	3 MOS.	
certificate fing physic ygiene pri	CERTIFICATION	cause. Enter UNDERLYIN CAUSE (Disease or Injur- thet initiated events resulting in death) LAST		DUE TO	(OR AS A	CONSEOU	ENCE OF	7):		-					-		
0 = 5 = 6	EB	- Tooling in dailing Exor	d.				-										
nd the	CAL	PART II. Other significen	t conditions	contributing to	death be	ut not rae	ouiting (n tha ur	derlying	g Cause (given in (Pert I.	24s. WAS AN PERFOR	MED?	AVI	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE	
0 5 5 5 6	MEDI	BRADY ARR	НҮТНМ	IAS					-				1 - YES 2	NO.		DEATH?	
AL RE e faw requi has been s Dept. of H 23 show		DID TOBACCO US			USE O	F DEATH	H YE	S 🗆 i	10 [UNC	ERTAIN	1 🗆					
ITAL I: The law cate has State Dep	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	_	HOSPITAL:		28. PLACE	OF DEAT	H (Check									
F VIT.	IXSI	1 TYES 2 NO		Inpatient 2				4 🗆 Nur	ung Hom		sidenca		er (Specify)				
O SE SE SE	ВУ РН	1 Natural 5 🗆 P	ending vestigation	28e. DATE OF (Month, E			28b. TIM INJ	E OF URY M		URY AT RK? /ES 2] NO	28d. DE	SCRIBE HOW IN	IJURY OCCUR	ED		
TSIC NTTENDI TOR: A after da			ould not be stermined	26s. PLACE C building,	of INJURY atc. (Speci	— At home	e, ferm, s	treet, fact	ory, office			28t. LOC City	CATION (Street a or Town, State)	nd Number or	Rural Route	Number,	
로 그 오 늘	COMPLET			AN: To the best of On the bests of e											suse(s) en	d manner es stated.	
TO THE HOSPIT TO THE FUNERA Be filed within 7	8	296. SIGNATURE AND TITLE (F CERTIFIER	Pa	∞	P. In	0	217			NSE NUM	BER		29d. DATE S	GNED (Mc	onth, Day, Year)	
⊼ 5 3 3	٥		D ADDRESS OF SERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) NDER P. MEHTA, M.D., 7620 YORK ROAD, TOWSON, MD. 21204														
								AD,	TOW	SON,	MD.	2120	4				
		NOV 3 0 1994 32. REGISTRAR'S SIGNATURE PARALLE															

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

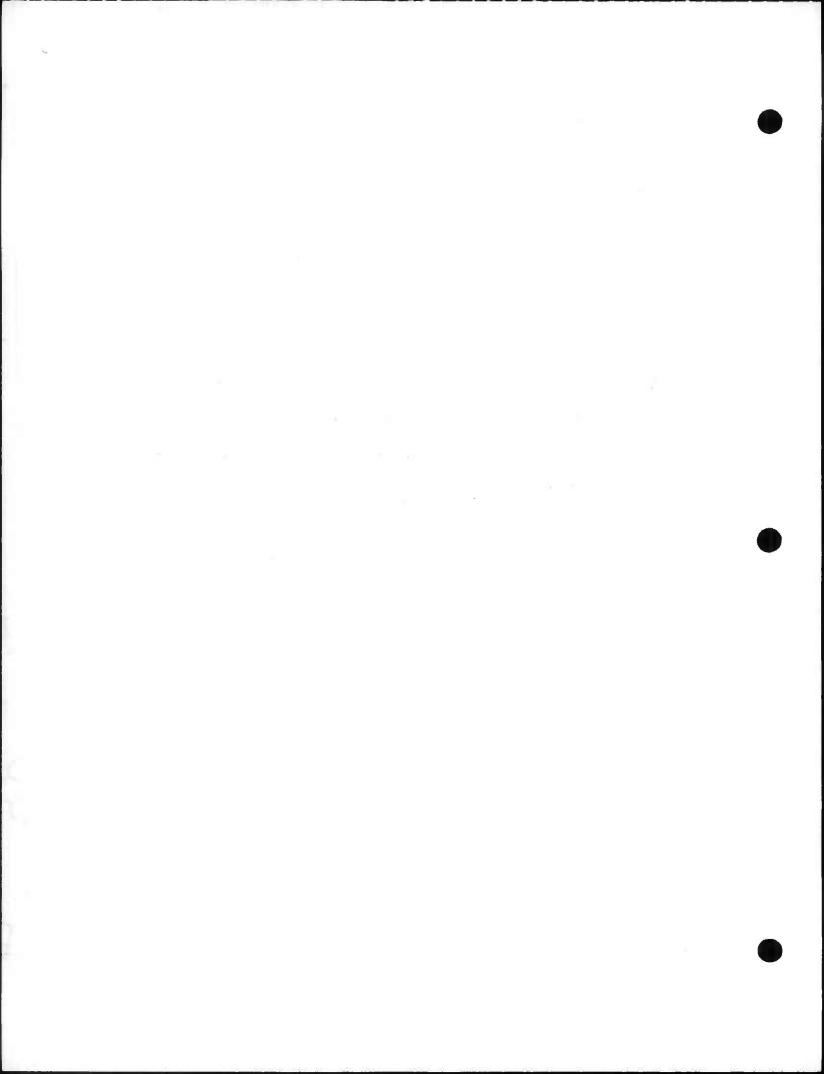
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. or Health and Mental Hypher prior to removal.

IMPORTANT: It item 28 is marked on item 23 shows any injury, or other transmatter event the market are an exemple of the property of the permit of the permit of the permit of the property of the permit of the

1 - STATE OF MARYLAND / DEPARTME CERTIFICATE CERTIFICA

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	REGISTRAR	KITIFIC	AIE	F DEATH		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) Catharine Eleanor RUDESILL				MON	E OF DEATH	ÿ - 9	YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last)	hirthday) IE	F UNDER 1 YEAR	IF UNDER 24 I		OF BIRTH	7		PLACE (State or Foreign	
	214-16-1573 1	YRS. MO	ONTHS DAYS	HOURS N	Jui	ne 7, 1	907	Country	land	
	9a. FACILITY NAME (If not institution, give street and number)	90	b. CITY, TOWI	OR LOCATION	OF DEATH		9c. COU	NTY OF DE	ATH	
DIRECTOR	Washington County Hospital		Hag	erstown	1		u	Dashin	nation	
Ĭ	10a. STATE 10b. COUNTY	10c. CITY, T	OWH OR LOC	ATION					10d. INSIDE CITY	
1 2	Maryland Washington Hagerstown 12 718 COSE 100 NO NO NO NO NO NO NO NO NO NO NO NO NO									
FUNERAL	115 Catawba Place			10f. ZIP COOE 2174	0		10g. CIT	IZEN OF W	HAT COUNTRY?	
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARM	ED		ECENDENT OF H			or No-	14. RACE	- American Indian, White, atc.	
BY F	1	,		specify Cuban, N ES 2 💢 NO		Rican, atc.)		Specifi		
	3 A Widowed 4 Divorced		1	122			- 1	whi	te	
	15. DECEDENT'S EDUCATION 16a. DECI (Specify only highest grade completed) (Give	EDENT'S USI	UAL OCCUPA	TION nost of working	16	b. KIND OF BUS	SINESS/INC	DUSTRY		
l iii	College (1-4 or 5+)									
COMPLETED	8 0 h	nousew	/11e			her o		оте		
TO BE COM	Wilbur A. Beard				aara I	Middle, Maiden	2 ,	ara	Levie	
TO B	19e. INFORMANT'S NAME (Type/Print) Gloria E. Gabe	MAILING AD	Canno	n Ave.,	Rural Route Nur	nber, City or Town	n, State, Zip	Code)	0	
12011	200, METHOD OF DISPOSITION 20b. PLACE AN	ND DATE OF D	DISPOSITION		nager			City or Tow		
200	4 Donation 5 Other (Specify) Rest	Haven	Ceme		12-2-9	4 Hag			aryland	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		MINN	ICH FUN	ERAL H	OME				
a de la composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della composition della comp	ScottMunice	R	415	E. Wils	on Blv	d., Ha	gersi	town,	Md. 21740	
200	23. PART I. Enter the diseases, or complications that caused the deer shock, or heart feliure. List only one cause on each line.	th. Do not	enter the n	node of dying,	auch es ce	diec or reepi	ratory an	reet,	Approximate	
	IMMEDIATE CAUSE (Fine)								Interval Between Onaet and Death	
-	disesse or condition	o an	1111	0.	1 7	1 :				
	disease or condition resulting in desth) e. Condisc resulting DUE TO (OR AS A CONSEQUE	JENCE OF):	· un	le in	gares	COL				
N N	Sequentially list conditions b. Coronary	eerse	ers a	linear	rl_					
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	JENCE OF):	/							
	CAUSE (Diseese or injury & c. acturoscur	un.								
	that initieted eventa OUE TO (OR AS A CONSEOU resulting in deeth) LAST	JENCE OF):							i	
	d									
	PART II. Other eignificent conditione contributing to death but not rea	suiting in t	he underly	ng ceuse give	n in Part i.	24s. WAS AN			WERE AUTOPSY FINDINGS	
EDICAL	Diabete burge The	-				PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE	
	H					I TES 2	NO	- 1	OF DEATH?	
Σ.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH	H VES		UNCER	TAIN D			- [1 - YES 2 - NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE		Check only on		IAIN L					
	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpellent 2 ER/Outpetlent 3	0	THER:							
		286. TIME O	-	me 5 Realde		SCRIBE HOW IN	I II IBY OO	CHRED		
BY PI	1 Astural 5 Pending (Month, Day, Year) 2 Accident Investigation	INJURY	V	ORK?		SCHIBE HOW IF	430HT OC	LONED		
9	3 Suicide 6 Could not be 4 Homicide determined	e, farm, stree	et, tectory, of	Ice	28t, LO	CATION (Street a or Town, State)	nd Number	or Rural Ro	ute Number,	
	20a CERTIFIED									
COMPL	(Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. Description one one of the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. Description one of the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LtCENSI					Month, Day, Year)	
TO B	10 mederics (111) D325-18 11/30/99									
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
	31. DATE FILEO (Month, Day, Year) A 32. REGISTRAR'S SIGNATURE									
	DEC 0 2 1994 Juli Deniew Rules									



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation. or remonal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	HEGISTRAR			ERITH	CATE OF	DEATH	REG.	NO.	
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEAT	H	3. TIME OF OEATH
	Robert Leon RITC	HIE					MONTH A/O 1/	27	1994 1330 M
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. OATE OF BIRTH		8. BIRTHPLACE (State or Foreign
	220-28-3952	1 🔀 M 2 🗌 F	63	YRS.	MONTHS DAYS	HOURS MIN.	Sept.9,		Country)
	9a. FACILITY NAME (If not institution, give :	street and number)	- 03		9b. CITY. TOWN	OR LOCATION OF			Maryland
Œ	Washington Count	v II	1			10			
ΙĶ	Washington Count	y nospita	1.1		над	erstown		Wa	shington
DIRECTOR	10a. STATE 10b. COUNT	Υ		10c. CITY	TOWN OR LOC	ATION			10d. INSIDE CITY
E	Maryland Wash	ington		H:	gersto	-Pro			1 YES 2 NO
	10e. STREET AND NUMBER	ZIIACOII		1 116		Of, ZIP CODE		10a CIT	IZEN OF WHAT COUNTRY?
FUNERAL	136 East Washing	ton Ctros	. 4-					100.01	USA
Z	11. MARITAL STATUS	12. WAS DECEDENT		MED	12 WES DE	21740	ANIC ORIGIN? (Specif	Was as Ma	
	1 Never Married 2 X Married	FORCES? 1 IF YES, GIVE W	YES 2 1	NO	If yes, s	pecify Cuban, Maxic	an, Puerto Rican, atc)	14. RACE — American Indian, Black, White, atc.
B	3 Widowed 4 Divorced	195			1 U YE	S 2 XNO Spec	ity:		Specify: White
COMPLETED	15. OECEDENT'S EDU	CATION	16a. DE	CEDENT'S	USUAL OCCUPAT	ION	16b, KIND OF	BUSINESS/INI	
E	(Specify only highest grade	College (1-4 or 5 +	(G life	ive kind of w . Do NOT us	ork done during n retired.)	nost of working			
7	12	3		super	visor		plu	mbine/	heating
8	17. FATHER'S NAME (First, Middle, Last)					16 MOTHER'S M	AME (First, Middle, Me		
	Raymond Alder Ri	tchie					t Leon F		or
BE	19a. INFORMANT'S NAME (Type/Print)		10	h MAILING	ADDRESS /Dansel		Route Number, City of		
임	Thelma M. Ritchi	9							Md. 21740
	20s. METHOD OF DISPOSITION								
	1 1 Burial 2 □ Cremation 3 □ Ram	oval from State	cemetery cre	metony or oti	F DISPOSITION (f				City or Town, State
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIK	PENERE	Ceda	r Law				Hage:	rstown,Maryland
	11. SIGNATURE OF PUNERAL SERVICE LA	200	, -		MINN	CH FUNE	AL HOME		
	2001	1/14	inne	en	415 E	. Wilson	Blvd	Hagers	town, Md. 21740
	23. PART I. Enter the diseesea, or	complications that	ceused the de	ath. Do n					
	anock, or heart failure.	List only one caus	se on each line).					interval Between
	IMMEDIATE CAUSE (Final disease or condition	Caro	DA			-)			Onaet and Daath
1 1	resulting in death)	a. COVICE TO	OR AS A CONSE	MONA	My W	HEST			
_	_	C	Day of	O .		nest as deser			
💆	Sequentially list conditions,	b. DUE TO	OR AS A CONSEC	DUENCE OF	y coul	an also	ase		
I A	if any, leading to immediate cause. Entar UNDERLYING	Consti	0 240 4	00	A 0 8 4	to 1			
[윤]	CAUSE (Disease or Injury that initiated events	c. DUE TO	OR AS A CONSEC	DUENCE OF	Nacc	ally			
 	resulting in death) LAST				•				
CERTIFICATION		d		-					
	PART ii. Other aignificent condition	a contributing to	death but not r	esulting is	the underlyle	ng csuse givan in		AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
EDICAL								FORMED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE
							¹ 🗆 YE	2 NO	OF DEATH?
Σ	DID TORACCO LISE CONT	DIDLITE TO CAL	ICE OF DEA	TIL VE		7			1 TES 2 NO
PHYSICIAN:	DID TOBACCO USE CONT	RIBUTE TO CAL			O L NO L		иПТ		
I I	EXAMINER?	HOSPITAL:		1	OTHER:)			
ΙŁS	1 YES 2 NO		ER/Outpatient 3	1			8 Other (Specify)		
표	1 Netural 5 Pending	28e. DATE OF (Month, Da		28b. TIME INJU	RY W	JURY AT ORK?	28d. DEŞCRIBE H	W INJURY OC	CURED
B	2 Accident Investigation					YES 2 NO			
8	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF building, a	INJURY — At horac. (Specify)	me, Jerm, st	reet, lectory, offi	ce	281. LOCATION (St. City or Town, S	eet end Number late)	or Rural Route Number,
E	- Inditional determined								
급	29a. CERTIFIER Check only	CIAN: To the best of a	ny knowladge, da	ath occurred	at the Jime, dat	e and pleca, and du	s to the cause(s) and	menner as stat	led.
OMPL									na cause(a) and menner as stated.
O	296. SIGNATURE AND TITLE OF CENTIFIES			_		29c, LICENSE NU		_	
8	(NH)	11				TO LICENSE NO	1111	29d, DAT	E SIGNED (Mogth, Day, Year)
	30. NAME AND ADDRESS OF SERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
유	30. NAME AND ADDRESS OF SERSONAUL	O COMPLETED CALLS			PTIME!				
ř	this in lile	2001	E OF DEATH (ITE	A Co	11	101	11.	100 /	
ř	Eric m Wa.	65 nal	179	19	Howel	1 Rd.	HAG.	Md	
)T	this in lile	32. REGISTRAF	179	19	Howel	1 Rd.	Hag.	Md	

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or requires that the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ITEMS: 23 PART I, 27, 28b,d,e,f, PER MEO FILM G-718 12/30/94 t.t

	1 STATE REGISTRAR	SIAIE UF I	/ CI	ERTIF	ICATE C	F DEA	TH		GIENI G. NO.				
1	1. DECEDENT'S NAME (First, Middle, L	est)						2. DATE OF OE	ATH DA		YEAR	3. TIME OF DEA	TH
1	MICHAEL	ANDREW	RED	WINE				NOV. 2				03:59	Ам
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	t birthday)	IF UNDER 1 YEA		R 24 HRS.	7. DATE OF BIR (Month, Day,	TH			IPLACE (State or Fe	
	217-88-0304	¥ M 2 □ F	32	YRS.	WOMINS DAT	s HOURS	wire.	11-06-		2		nington,	DC
_	9a. FACILITY NAME (If not institution, g	live street and number)			9b. CITY, TOV	N OR LOCAT	ION OF DE	ATH		9c. COU	NTY OF D		
5	N.B.RT.5 BRAI	NCH AVE.				LINTO	N			PRI	NCE	GEORG	ES
Diameter 1	10s. STATE 10b. CO			10c. CIT	Y, TOWN OR LO	CATION						10d. INSIDE CITY	,
DIRECTOR	Maryland C	narles		W	aldorf							LIMITS?	
1	10e. STREET AND NUMBER					10f. ZIP COC	E			10g. CIT	IZEN OF W	VHAT COUNTRY?	
ER	4364 Eagle Cour	rt				20	602			1	JSA		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR			DECENDENT	OF HISPAN	IIC ORIGIN? (Spe			14. RACE	— American Indi	en,
ВУ Б	1 X Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE V	YES 2 YES	40		ES 2 NO		n, Puerto Rican, a	rtc.)		Speci	y this atc.	
												"White	
E	15. OECEDENT'S (Specify only highest of	grade completed)	(G	ive kind of	WORK done during se retired.)	ATION most of world	ing	16b. KIND	OF BUS	INESS/INC	DUSTRY		
P	Elementary/Secondary (0-12)	College (1-4 or 5		bore				Pr	ivat	te			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		-		16. MOT	HER'S NA	ME (First, Middle, i	Maiden S	Sumame)			
UI UI	William A. Redy	vina						Morris			مغيباه		
00	19a. INFORMANT'S NAME (Type/Print)	11110	191	b. MAILING	ADDRESS (Stre	et and Numbe	r or Rural F	Poute Number, City	or Town	, State, Zip	Code)	16	
은	Wendy Jo Carro	11	4	364	Eagle C	ourt 1	Waldo	orf, MD	206	502			
	20a. METHOD OF DISPOSITION 1 Burlei 2X Cremetion 3	Removal from State		ANDDATE	OF DISPOSITION						City or To	wn, Stata	
	4 Donation A Other (Specify)				atory		_11-	29-94	C1:	intor	n MD	20735	
	21. SIGNATURE OF FUNDAL SERVIC	LICENSEE .				AND ADDRE	SS OF FA	CILITY					
	Whole /	leuren)		1//33	Lber!	nein O Dia	Mortua	ry Jhit	- D I		MD 2069	_
	23. PARTY I. Enter the diseasea,	or complications tha	t caused the de	ath. Do	not enter the	mode of dy	ing, auci	h ea cerdiec or	reepir	atory an	reet,	Approxim	ata
1	IMMEDIATE CAUSE (Finel	ne. Liet only one cat	ioe on each line	,								Onset and	
	disease or condition resulting in death)	a. MULTIPL	E INJURIES	S									
		DUE TO	(OR AS A CONSEC	DUENCE O	F):								
8	Sequentially list conditione,	b. DUE TO	(OR AS A CONSEC	NIENCE O	6.								
¥	if any, leading to immediate cause. Enter UNDERLYING	302.10	(OII AS A CONSEC	JOENCE O	r.j.								- 1
CERTIFICATION	CAUSE (Diseese or injury that initieted eventa	C. DUE TO	(OR AS A CONSEC	DUENCE O	F):							-	
ᇤ	resulting in death) LAST	d											
	PART II. Other eignificant cond	tions contributing to	death but not r	egultina	in the underl	dog cause	alvan la	Port I Dr. 1		WITOPSY	Lan		
MEDICAL		The state of the s	doon but not t	counting	in the dilderi	ing couse	given in	P	ERFOR	MED?	240.	WERE AUTOPSY FI AVAILABLE PRIOR COMPLETION OF C	TO
								- 15	YES 2	□ NO		OF DEATH?	JAUSE
	DID TOBACCO USE CO	NTDIRLITE TO CA	LICE OF DEV	TLI VI			ERTAIN					1 YES 2	NO
AN	25. WAS CASE REFERRED TO MEDICA				TH (Check only o		CKIAII	ч 🗆 📗					
S	EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER:		ealdence	6 (YOther (Speci	(64)	0030	T. T. D. 3.7		
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF	INJURY	28b. T/N	E OF 28c.	INJURY AT	anounca			SOAD	CUREDDE	DESTRIAN	-
ВУ Р	1 Natural 5 Pending 2 Accident Investigat	on 11-25-		2:00	AM 1	WORK? YES 2	у но	Struc		_	tomot		
	3 Suicide 8 Could not	28a. PLACE O	F INJURY — At her	me, farm,	street, factory, o	ffice	^	28f. LOCATION (Charles and an	4.44	or Rural A	loute Number,	
E	4 Homicide determine	st Rt	5 North	Bou	nd ROA	YAWC		City or lown	, State R		linto	ANCH AVE.	
P.E	29a. CERTIFIER (Check only	HYSICIAN: To the best of	my knowledge, de	ath occurr	ed at the time, o	lata and place	, and dua	to the cause(s) s	nd man				
COMPLETED	ann)	MINER: On the beats of a										and menner as s	tated.
ш	296. SGNATURE AND TITLE DE CERT	TFIER ())				29c. LIC	ENSE NUM	IBER		29d. DAT	E SIGNED	(Month, Day, Year)	$\neg \neg$
00	Moyonte	eyfull				00	ME			► N	ov.	26,1994	4
5	30. NAME AND ADDRESS OF PERSON		SE OF DEATH (ITER	vi 27) (Type	, Print)								
	MASYNAMOD 13	-10REL	W) 1:	11 F	enn S	treet	, B	altimo	re,	Ma	ryla	and 212	201
	31. DATE FILED (Month, Day, Year)	32. REGISTRA	HIS SIGNATURE	and the									
	1101 0 0 1	June June			,								

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

The invalual on strength than the state of t
TO THE MOSTIAL OR ALLEMENTOR PRISIDING. THE LAW REGIONS THAT THE LAW REGION OF THE PRISIDING THE MOSTIAL OF ALLEMENTOR OF THE MOSTIAL OF ALLEMENTOR OF THE MOSTIAL OF ALLEMENTOR OF THE MOSTIAL OF ALLEMENTOR OF THE MOSTIAL OF ALLEMENTOR OF THE MOSTIAL OF ALLEMENTOR OF THE MOSTIAL OF THE MOSTI
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	for STATE REGISTRAR	STATE OF MARYLAI	ND / DEPAR				MENTAL HYG			
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEAT		WEAR	3. TIME OF DEATH
1	1/4	KENNETH PAI	LMER TAY	YLOR			12	3	94	0630 M
1	A CONTRACTOR OF THE PROPERTY O		yrs. lest birthday)	IF UNDER		IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTI (Month, Day, Ye.		8. BIRTI	HPLACE (State or Foreign
	-20 20 0022	№ 2 □ F	65 YRS.	WOWTHS	DAYS	HOURS MIN.	1/23/1			ryland
_	9a. FACILITY NAME (If not institution, give stree			9b. CITY	TOWN OR	LOCATION OF D	EATH	9c. COUN	ITY OF D	DEATH
DIRECTOR	Frederick Memorial	. Hospital		Fr	eder	ick		Fred	leri	ck
E C	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN C	OR LOCATIO	ON				10d. INSIDE CITY
뜸	Maryland Frede	rick	Fı	ceder	rick					LIMITS?
	10s. STREET AND NUMBER			cuci		ZIP CODE		10g. CITI	ZEN OF	WHAT COUNTRY?
FUNERAL	104 Mercer Court S	uite 14-2B				21701			11.5	S.A.
5		2. WAS DECEDENT EVER IN L	J.S. ARMED	13.	WAS DECE	NDENT OF HISPA	NIC ORIGIN? (Specif	y Yee or No—	14. RAC	E — American Indian.
BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	ES NO			offy Cuben, Mexico	in, Puerto Rican, etc	-)	Spec	
		Peacetime								White
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	mpleted)	6a. DECEDENT'S (Give kind of a life. Do NOT us	work done i			16b. KIND O	F BUSINESS/IND	USTRY	1
12	12 years	College (1-4 or 5+)	Railro		incin	002	None			
NO.	17. FATHER'S NAME (First, Middle, Lest)		Naiil	au E			ME (First, Middle, Mi	ridea Commune		
	Palmer George Tayl	or					ia Thelm		na	
8E	19e. INFORMANT'S NAME (Type/Print)		19b, MAILING	ADDRESS	S (Street end		Route Number, City o			
유	Mildred L. Taylor								,	, MD 21701
	20s. METHOD OF DISPOSITION	20b. P	LACEANDDATE	OF DISPOS	ITION /Nam	e of	DATE 20	c. LOCATION — I	City or Tr	own State
	1 Donstion 5 Other (Specify)	I from Stata Res	ery, crematory or o	Memo	rial	Garden	s 12/5	Frederi	ck.	Maryland
	21. SIGNATURE OF TUNERAL SERVICE LICEN	SEE		22.	NAME AND	ADDRESS OF FA	CILITY			
	1/1/5	11-0-11								HOMES, P.A.
	23. PART i. Enter the diseases, or con	nplications that caused t	he death. Do r	not antar	the mod	e of dving, suc	th sa cardiac or i	F KEDEK	TUK :	MD 21701
	ahock, or haart fallura. Lia	it Dnly ona cause on aac	h Ilna.							interval Between
	disease or condition	DUE TO (OR AS A CO	stun	no	tem	far	lure			Onset sild Daatii
	resulting in death)	DUE TO (OR AS A	NSEQUENCE O	F):		0				
z		lina (una	1	+1	ushn	wilin	· trui	me	,
일	il sily, readility to illillediate	DUE TO TOR AS A C	ONSEQUENCE OF	F):		()	100.0			
2	cause, Entar UNDERLYING CAUSE (Disease or injury	June 1	fall	me				·		
E	that initiated events resulting in death) LAST	DUE TO (OR AS A C	ONSEQUENCE OF	F):						
CERTIFICATION	4	supon								
AL (PART II. Other significant conditions of	ontributing to death but	not reaulting	in the un	derlying	cause givan in		S AN AUTOPSY	245	. WERE AUTOPSY FINDINGS
								RFORMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
MEDIC						-				1 YES 2 NO
	DID TOBACCO USE CO	ONTRIBUTE TO	CAUSE O	F DEA	TH Y	ES IN	0 🔲			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	IOSPITAL:		OTHER		CE OF DEATH (C	neck only one)			
YSI	1 TYES 2 NO 1	Inpatient 2 - ER/Outpati	lant 3 DOA			5 - Residence	8 Other (Specify)		
표	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM INJ	E OF IURY	28c. INJUI		28d. DEŞCRIBE H	OW INJURY OCC	URED	
B	2 Accident Investigation			M		S 2 NO				
8	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — building, stc. (Specify	At home, term, i	street, tact	ory, offica		261. LOCATION (S) City or Town,	treet end Number State)	or Rural i	Route Number,
H.	an armirina a di			_						
COMPLETED		N: To the best of my knowled								
8	MEDICAL EXAMINER:	On the basis of examination s	end/or investigation	n, in my o	pinion, des	ith occured at the	time, date end plac	e, end due to the	e cause(e) end manner as stated.
BE (296. SPARTURE AND TITLE OF CERTIFIER FOR MCMVLAS FORUS MAP) 296. LICENSE NUMBER 29d. DATE SIGNED, (Month, Day, Year)									
10	TOTAL STATE SURCEON 043872 (IND) 1 TOTS/17									
	PAUL MENTIL	COMPLETED CAUSE OF DEATH	H (ITEM 27) (Type,	Print)	mso	W MR	ERED	MICE	un	0 21702
	31. DATE FILED (Month, Day, Year),			0011	,,	7	11-00	- June	** (.3	21/0
	120/53/85/1994	Moden	Rarball							

Amended #1,12/2/94, SLW, Calvert Co.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATN YEAR SAMUEL LENOIR THOMAS NOV 94 12:29 4. SOCIAL SECURITY NUMBER 5. SEY IF UNDER 1 YEAR IF UNDER 24 HRS. 6. AGE (In yrs. last birthday) 7. DATE OF BIRTN (Month, Day, Year) 8. BIRTNPLACE (State or Foreign DAYS 220-28-5381 1X M 2 F 66 March 18-1928 Maryland Pages 1, 2, 3 should 9s. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR 8226 STEVENS ROAD CALVERT COUNTY OWINGS RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Calvert Owings 1 🗌 YES 2 🎦 NO permit. 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 8226 Stevens Road burial-transit 20736 USA hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES: 1-2 YES 2 \square NO In Let wive war or dates $1951\!-\!1953$ 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No-14. RACE — American Indian, Black, White, atc. **MARYLAND 21215-0020** If yes, specify Cuban, Mexican, Puarlo Rican, etc.) 1 Never Married 2 Married 1 YES 2 NO Specify: Specify: Black BY 3 Widowed 4 Divorced use as the ED 18a. OECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b, KIND OF BUSINESS/INDUSTRY (Specify only high Щ 10 Elementary/Secondary (0-12) College (1-4 or 5+) COMPL detached 12 Truck Driver 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ĕ funeral director, page 5 should be David H. Thomas, Grace M. McIntyre notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Cora Thomas P.O. Box 342 Owings, Maryland 20736 BALTIMORE, be 20a. METHOD OF DISPOSITION
1 ☑ Burlal 2 ☐ Cremation 3 ☐ Removal from Stata OATE 20b. PLACE ANO DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata must MaryTand Veterans Cem. 12/02/94 Cheltenham, Md 4 Donation 8 Other (Specify) the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Sewell Funeral Home 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, 1451 Dares Beach Rd. Prince Frederick, physician and completely filled in by the ne prior to burial, cremation, or removal. Approximate Interval Between IMMEDIATE CAUSE (Fine) **Onset and Death** disease or condition resulting in death) SHOTGUIL WOUND TO HEDD executed within event. DIVISION OF VITAL RECORDS, P.O. BOX 68760 DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other Mental Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 0 injury. the PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO signed by the Health and I shows any COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 TYES 2 NO has been a DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: item 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) certificate the State HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ATTENDING PHYSICIAN: 1X XYES 2 □ NO 4 ☐ Nursing Nome 5 ☐ Residence 8 ☐ Other (Specify) the or 27. MANNER OF GEATH 28a, DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. OEŞCRIBE HOW INJURY OCCURED this c 28 is marked, 1 Natural 5 Pending 28e PLACE OF INJURY — At home, ferm, street, factory, office 1 YES 2 NO SUNDELT SHOT B After 2 Accident Investigation 3 Sufcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) S Could not be determined COMPLETED MUD DIRECTOR: / 8224 STEVENUSED OWNYS 4 Homicide AT HOME 26 STEVENING --COUVERT OR 29s. CERTIFIER

(Check onto 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. FUNERAL within 72 h = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II 2 😾 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, data and place, and due to the ceuse(s) and manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) H NOV 27, 1994 O.C.M.E. 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HARDEDAUTS · KOREL 111 Penn Street, Baltimore, Maryland 21201 5 31, DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 1: Savelin Rardall 1994

BALLIMORE, MARTLAND 21215-0020	YSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.	0 TME FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Moderne prior to burial, cremation, or removal.	the medical examinar must be notified at once
CIVISION OF VITAL NECONDS, F.O. BOA 66/60. BALLIMORE, MARTLAND 21215-0020	O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	D THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f e filed within 72 hours after death with the State Debt, of Health and Mental Mgiene prior to burial, cremation, or removal.	WPORTANT: If item 28 is marked, or litem 23 shows any injury or other traumatic event, the medical examiner must be notified at once

1/	Amended #	90 ///	22/21/	44	<i>^</i>	$m \perp$	94	37104	
	FOR 1 - STATE REGISTRAR	99 /// STATE OF MARYL	AND / DEPARTM CERTIFIC	MENT OF I	HEALTH AND	MENTAL HYGIEN	EJO1	mery (Junt
	1. OECEDENT'S NAME (First, Middle, Last)	Taman		AIL OI	DEATH	2. DATE OF OEATH	~a3 1	1994 1 0 DEA	тн Р м
	204-50-8355	□ M 2 F	37 YRS.	UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) May 21, 1	-	a. BIRTHPLACE (State or F Country) Pennsylvani	
TOR	96. FACILITY NAME (If not institution, give street Shady Grove Adventi	TI OS	721/911	city, town	n location of d	EATH	l	tgomery	
DIRECTOR	10a. STATE 10b. COUNTY Maryland Montgom	ery		own or loca intown	LION			10d. INSIDE CIT LIMITS? 1 YES 2	
FUNERAL	18503 Splitrock Lan	. WAS DECEDENT EVER IN	ALLE ABARE	2	0874		Unit	ted States	
BY	1 Never Merried 2 Merried	FORCES? 1 TYPES IF YES, GIVE WAR OR DI	2 NO	If yee, ap	ecify Cuben, Mexico	NIC ORIGIN? (Specify Yeen, Puerto Rican, etc.) fy:	s or No	14. RACE — American Ind Black, White, etc. Specify: White	ien,
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade com Elementary/Secondary (0-12) C		18a. DECEDENT'S US (Give kind of work life. Do NOT use re Home Make	done during mo tired.)	ON est of working	Own Hon		DUSTRY	
BE COM	17. FATHER'S NAME (First, Middle, Last) Robert G.	Ba	arnhart		THE STATE OF THE S	ME (First, Middle, Meider te Elnora	Surname)	1	
TO B	19. INFORMANT'S NAME (Type/Print) Lance K. Tamanaka		18503 S	plitro	ck Ln.,	Route Number, City or Tow Germantown	n, Stete, Zip	Code)	
	20e. METHOD OF DISPOSITION 1	Irom State Cem	PLACEANDDATEOFE elery, cremetory or other tropolital	n Crema	atory ND ADDRESS OF FA	11/25 A1		city or Yown, Stata ria, Virgin	ia
	9.3.	SP_		DeVol 10 E.	Funeral Deer Par	Home k Dr., Gai	thers	sburg, MD 20	0877
10	23. PART I. Enter the diseases, or com- ahock, or hear feilure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	only one ceuse on el	ech line.		de of dying, suc	th an cerdlec or reep	iratory arr	Approximinterval E Onset en 2. dev	d Death
TION	Sequentially list conditions,	Alcoholic 1: DUE TO (OR AS A						440	
RTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	Al coldism DUE TO (OR AS A	CONSEQUENCE OF):					Yea	3
ICAL CER	PART ii. Other algnificant conditione co	ontributing to deeth b	ut not resulting in t	he underlyin	g ceuse given in	Pert I. 24a. WAS AN PERFO	RMED?	24b. WERE AUTOPSY F AVAILABLE PRIOR COMPLETION OF	TO
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIB	UTE TO CAUSE O	F DEATH YES	□ NO Z	UNCERTAI		A NO	OF DEATH?	но
YSICIA	1 YES 2 NO	OSPITAL: Support 2 ER/Outp		THER:	e 5 🗆 Residence	6 Other (Specify)			
B	27. MANNER OF CEATH 1 Neturel 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY	28b. TIME OF INJURY	M 1 🗆	res 2 NO	28d. OESCRIBE HOW			
COMPLETED	3 Suicide S Could not be determined 29a. CERTIFIER	building, etc. (Spec	ity)			28f. LOCATION (Street City or Town, State)			
	29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: Of CERTIFIER					time, date end place, er	nd due lo the		
TO BE	30. NAME AND ADDRESS OF PERSON WHO CO				0388	31	▶ I	1/24/94	
	Peter N. Kan from no 5616 5 nicks Dr. Bethesde, ND 20817 31. DATE FILED (MONTH, Day, Year) NOV 2 9 1994 Julia Davidson-Andell								
	1101 to 9 1554 June transport further								

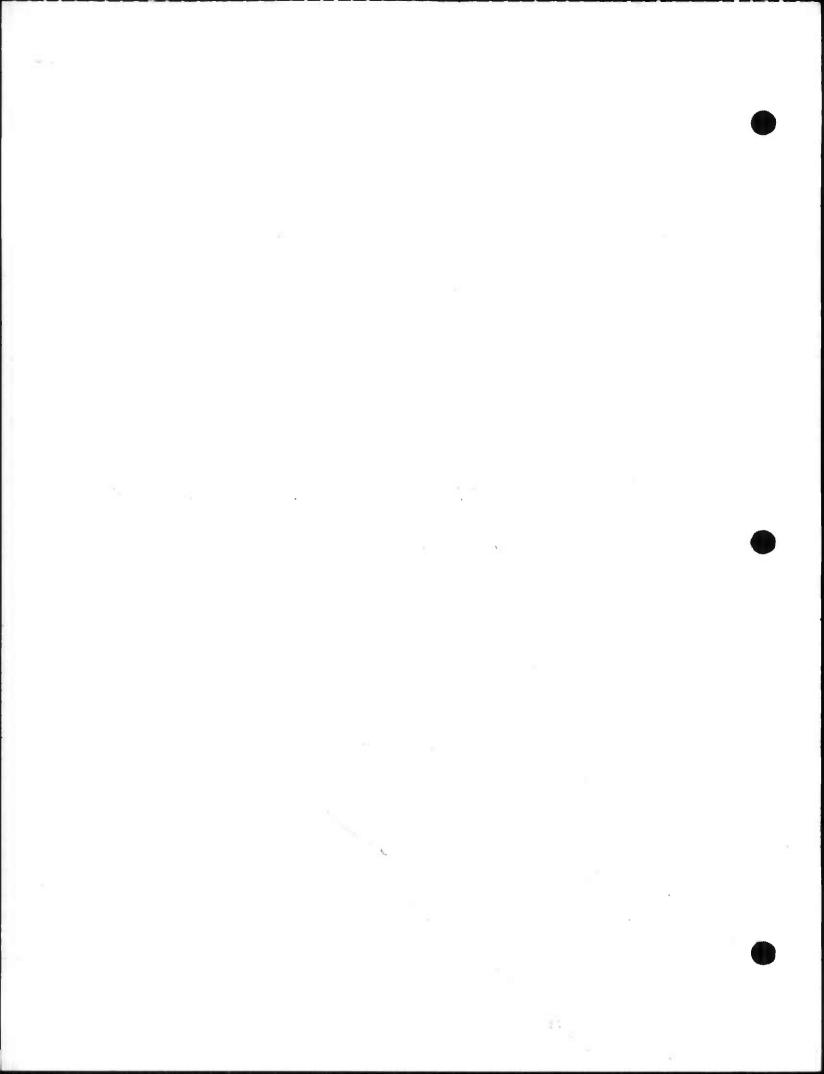
BALTIMORE, MARYLAND 21215-0020

BALTIMORE, MARYLAND 21215-0020	er nours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within rinours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.

IMPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR

	REGISTRAR				OLI	4111	IVAII	E UF	DEA	111		REG. NO.			
	1. DECEDENT'S NAME (First, i		verstine	Danio	la m	N					2. DATE OF MONTH	DA		YEAR	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBE									C V HILL	Novem		5,19		6:30Pm
		1H	5. SEX 1 M 2 F	6. AGE (In			MONTHS	DAYS	HOURS	R 24 HRS. MIN.	7. DATE OF (Month, D NOV.	BIRTH lay, Year)		Countr	PLACE (State or Foreign y)
	485-01-8967	Alb. Als Is -	21		83	YRS.						21,19			Iowa
oc	9e. FACILITY NAME (If not ins						9b. CIT			ION OF DE	EATH			NTY OF D	
힏	Manor Care-I		ic					Pot	comac				Mon	tgom	ery
S		10b. COUNTY	Υ			10c. CIT	Y, TOWN	OR LOCAT	TION						10d. INSIDE CITY
DIRECTOR	Maryland	M	Montgomer	У				Roc	kvi1	l1e					LIMITS?
AL	10e. STREET AND NUMBER							101	ZIP COD	Œ	-		10g. CIT	IZEN OF W	VHAT COUNTRY?
FUNERAL	5906 Ridgewa	ay Ave	enue						208	351			Uni	ted	States
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN	U.S. ARME	D	13.	WAS DEC	ENDENT (OF HISPAN	VIC ORIGIN? (Specify Yes	or No-	14. RACE	- American Indian,
BY F	1 Never Married 2 h		FORCES? 1 IF YES, GIVE W							an, Mexica Specify	n, Puerto Rici	en, etc.)		Specia	t, White, etc.
			1											Amer	ican Indian
COMPLETED		highest grade		1	16a. DECEI	kind of v	vork done	durina mo	ON st of worki	ing	16b. Ki	ND OF BUS	INESS/IN	DUSTRY	
٦	Elementary/Secondary (0-1	12)	College (1-4 or 5	+)			e retired.)						_		
M	17. FATHER'S NAME (First, Mid	1.00	5+		Wr	rite	r/Ec	litor				H.H.			
ဗ			. Daniels	!					18. MOT		ME (First, Mick	,	Sumame)		
BE	190. INFORMANT'S NAME (Tyr		Daniels		1 405 41	****	400000				_		-22		
5	Michael Turr	ner									Rock				nd 20851
	20e. METHOD OF DISPOSITION	ON a 3 □ Rem	oval from State	cemet	ery, cremat	tory or of	her place!				94DATE			City of To	
	4 Donation 5 Other (Specify)		Mon	rtgom	nery	Cre	emato	orium	n, Ir	nq.	Beth	esda	, Ma	ryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 122. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805														
	23. PART I. Enter the dis	seasea, or (complications the	t caused t	the death										Approximate
ı I	immediate cause (Fine		List only one cau	ise on esc	ch line.										interval Between Onset and Death
1	diseese or condition resulting in death)	<i></i>	Aspir	ation	n Pne	umo	nia								2 days
i	resulting in destiny		*	(OR AS A C											-
Z	Convention list on defe		L Cereb					cider	nt						months
E	Sequentially list condition if any, leading to immediate	llete		(OR AS A C		ENCE OF	7):								
CERTIFICATION	cause. Entar UNDERLYIN CAUSE (Disease or Injury		. Hyper												years
E	that initiated events resulting in deeth) LAST		DUE TO	(OR AS A C	ONSEQUE	ENCE OF	7):								
5			d												
اب	PART II. Other eignificen	it condition	e contributing to	deeth but	not reeu	ulting i	n the ur	nderlying	ceuse	given in	Part i. 24	a. WAS AN		24b.	WERE AUTOPSY FINDINGS
EDICAL												PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
											_ '	LI TES 2	N NO		DF DEATH?
Σ.	DID TOBACCO US	E CONT	RIBUTE TO CA	USE OF	DEATH	- YF	s 🖂	NO ₹	1 UNC	FRTAIN					TES 2 MINO
¥	25. WAS CASE REFERRED TO				. PLACE C				0110	- LIVIAII	1 1				
Sic	EXAMINER? 1 YES 2XXNO		HOSPITAL:	ER/Outpati	lent 3 🗆	DOA	OTHEI		e 5 □ B	esidence	8 Other (S	necifu)			
PHYSICIAN:	27. MANNER OF DEATH		28e. DATE OF	INJURY		28b. TIME	E OF	28c. INJ	URY AT		28d. DESCR		JURY OC	CURED	
BY F	1 Natural 5 P	ending restigation	(Month, Di	ay, rear)	_	LNI	M		RK? (ES 2	NO					
	2 Cut-ld-	Could not be	28e. PLACE O	F INJURY — etc. (Specify	At home,	, term, a	treet, tect	tory, office	•		281. LOCATIO	ON (Street e	nd Number	or Rural R	loute Number,
TEO	4 Homicide de	etermined		(-,,							City Or 1	own, State)			
COMPLET	29e. CERTIFIER (Check only	FYING PHYSI	ICIAN: To the best of	my knowled	dge, death	оссине	d at the t	Ime, date	end place	, end due	to the cause(s) end men	ner as atal	ed.	
8															end manner es stated.
	296. SIGNATHIE AND TITLE O	-				1			-	ENSE NUN		1			(Month, Day, Year)
H	411	3	2		1	/	m	27		00557		- 1			er 28, 1994
2	NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS	SE OF DEAT	H (ITEM 2	7) (Type,	Print)								
	Raymond T. I	Benack	<, M.D.,	4115	Co1i	ie D		e, Wł	neato	on, N	Mary1a	nd 2	20906	-446	5
	31. DATE FILED (Month, Day, 1904) ST. D. S. D.														



215-0020	attending physicia
MARYLAND 21	etained by the hospital or
BALTIMORE, MARYLAND 21215-0020	if the death certificate be executed within a curs after death. Page 6 may be retained by the hospital or attending physicia
	in Jours a
K 68760,	executed with
3DS, P.O. BOX 68760,	n certificate be
ADS, F	if the death

DIVISION OF VITAL RECOR

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Color after death. Page 6 may be retained by the hospital or attending physician.	TOP: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	alter death with the State Dept. Or regula any mental righers prior to content of the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAL	TO THE FUNERAL DIRECTOR: After this certif	IMPORTANT: If Item 28 is marked, or

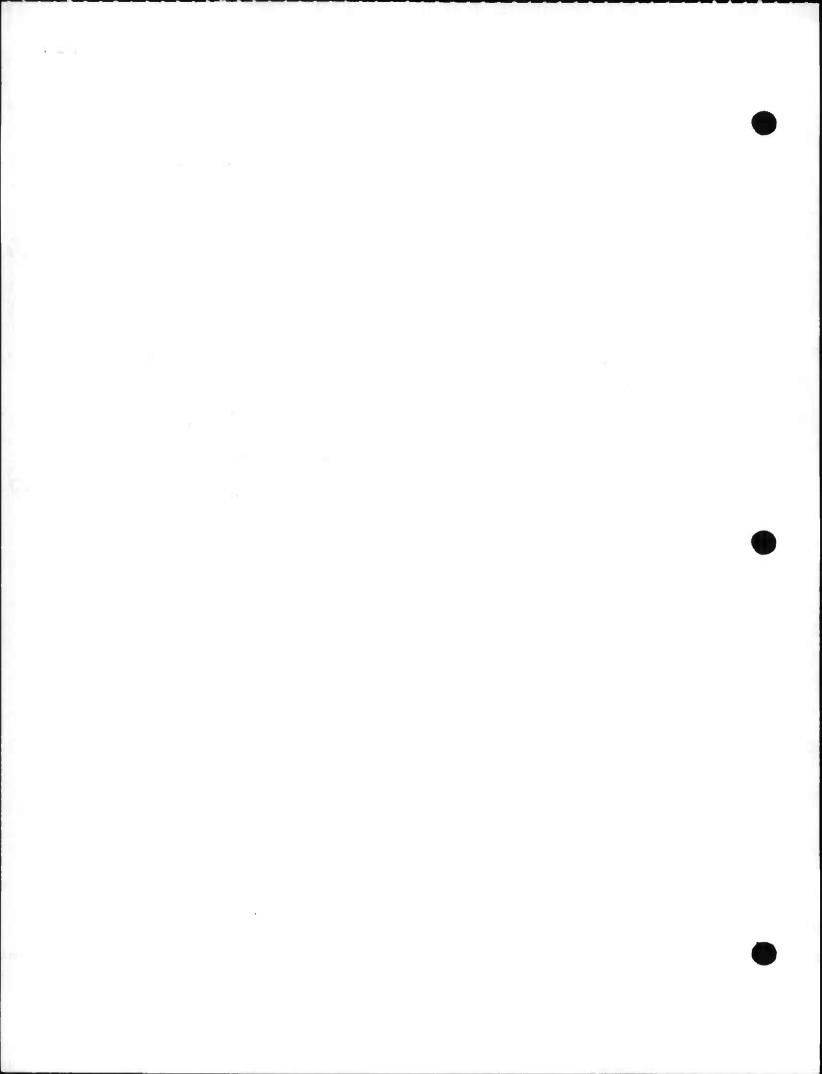
1 - FOR STATE REGISTRAR	SIAIE UF MART		NT OF HEALTH AND TE OF DEATH	REG. NO				
1. DECEDENT'S NAME (First, Middle, LI ELLIE D	AVIS TAVEN	INER		2. DATE OF DEATH MONTH November	Ž7, 19	3. TIME OF DEATH 94 6:50 P		
4. SOCIAL SECURITY NUMBER 578-09-1407	5. SEX 6. AG	92 YRS. MONTH	ER 1 YEAR IF UNDER 24 HRS. B DAYS HOURS MIN.	Jan. 17,		BIRTHPLACE (State or Foreign Country) enderson, NC		
9a. FACILITY NAME (If not institution, g Doctor's Commun	nity Hospital		ty, town or location of dana	PEATH	9c. COUNTY	of DEATH e George's		
nesidence of decedent 10a. STATE 10b. COI Maryland Prin			or Location			10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
100. STREET AND NUMBER 6520 40th Avenu		oniver	101. ZIP CODE 20782		U.S.A	N OF WHAT COUNTRY?		
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVEI FORCES? 1 _ YE IF YES, GIVE WAR OR	S 2 NO	3. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 X NO Spec	an, Puerto Rican, atc.)	os or No— 14	RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S (Specify only highest g		16a. DECEDENT'S USUAL (Give kind of work do life. Do NOT use retire	ne during most of working	16b. KIND OF BI	JSINESS/INDUS	TRY		
17. FATHER'S NAME (First, Middle, Last	2	Teacher	18. MOTHER'S N	Educat:				
Henry Alexander	r Davis	19b. MAILING ADDR	Lucy Bl	Lick Davis Route Number, City or To	wn, State, Zip Co	ode)		
Henry A. Taveni		6520 40t	h Avenue, Un	iversity Pa	ark, Ma	ryland 20782		
1 A Buriel 2 Cremetion 3 Removal from State 4 Denetion 5 Other (Specify)								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781								
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. OUE TO (OR A	S A CONSEQUENCE OF): S A CONSEQUENCE OF):	Inf.	unc lir	\	6 week		
PART II. Other significent cond	itiona contributing to deat	n but not resulting in the	underlying cause given i		N AUTOPSY DRMED? 2 NO	24b. WERE AUTOPSY FINDIN MAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO		
25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
1 YES 2 ONO	HOSPITAL:		Nursing Home 5 - Residence					
27. MANNER OF DEATH 1 Netural 6 Pending 2 Accident Investigat		r) INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. DEŞCRIBE HOW	OW INJURY OCCURED			
3 Suicide 6 Could not be detarmined 26s. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28ft. LOCATION (Street and Number or Rural Route City or Town, State)								
enel city	HYSICIAN: To the best of my ku							
			29c, LICENSE N					
296. SIGNATURE AND TITLE OF CENT	Mours	6	DON	896	> /	SIGNED (Month, Day, Year)		
H /1/1	N WHO COMPLETED CAUSE OF	DEATH (ITEM 27) (Type, Print) FULL IN GENATURE UN SON-PONSALL	DON	894	> //	BIGNED (Month, pey, Year)		

 $U \gg \gamma \gamma$

DIVISION OF VITAL RECORDS, P.O. BOX 68760

E HOSPITAL DR ATTENDING PHYSICIAN! The law requires that the death certificate be executed within Exhours after death. Page 6 may be retained by the hospital or attending physician.	HE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should led within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	OFTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HO	TO THE FUN	MPORTA

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG. NO						
	1. DECEDENT'S NAME (First, Middle, Last)		_			2. DATE OF DEATH		3	. TIME OF DEATH			
	MARY VIRGINIA	A TIP	TIPTON			November 25, 1994			11:20 P M			
	4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH						
- 5	579-28-1464	1 🗆 M 2 🔯 F	84 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)		Country)	ACE (State or Foreign			
		**	04	-		Jan. 7, 19						
~	9e. FACILITY NAME (If not institution, give s				OR LOCATION OF OR	EATN		TY OF DEA				
Ö	Golden Oaks Nurs	ing Home	Laure	1		Prin	ce Ge	eorge's				
<u>[</u> 5	RESIDENCE OF DECEDENT 100. STATE 10b. COUNT	v		TY, TOWN OR LOCA								
DIRECTOR			170		71.71			1	0d. INSIDE CITY LIMITS?			
0		ce George's	Нуа	attsvill				1	X YES 2 NO			
M	10e. STREET AND NUMBER				H. ZIP CODE				AT COUNTRY?			
삘	7214 Marywood Sti	ceet			20784		U.S.	Α.				
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARMEO	13. WAS DE	CENDENT OF HISPAN	NIC ORIGIN? (Specify Yes	or No-		- American Indian,			
7	1 Never Merried 2 Merried	FORCES? 1 Y		1 Tyes, s	S 2 X NO Specify	n, Puerto Rican, atc.)		Specify:	White, etc.			
ВУ	3 📉 Widowed 4 🗌 Divorced			-				.,,.	White			
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S	USUAL OCCUPAT	ION	16b. KIND OF BUS	SINESS/INDU	JSTRY				
<u> </u>	Elementary/Secondary (0-12)	Cotlege (1-4 or 5+)	life. Do NOT L	work done during no use retired.)	ost or working							
ם	(Unknown)		Clerk			Drug St	tore					
ő	17. FATHER'S NAME (First, Middle, Last)	77			16. MOTHER'S NA	ME (First, Middle, Maiden	Surname)					
	Oden W. Beall				Lula M.	. Fitzhugh						
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILIN	ADDRESS (Street		Route Number, City or Tow	n State Zin i	Codel				
2	Helen L. Matzen		13047	Hallsho	p Road. H	Highland, N	Marv1:	and 2	0777			
	20. METNOD OF DISPOSITION	Ť										
	1 🕅 Buriel 2 🗆 Cremelion 3 🗆 Rem	oval from Stale	20b. PLACE AND DATE cametery, crematory or	other place!		1	CATION — C					
	4 Donellon 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC		Fort Line			/30/94 Bre	ntwoo	d, Ma	aryland			
	21. SIGNATURE OF FUNERAL SERVICE LIN	CENSEE	Franc	ND ADDRESS OF FA	CILITY Sone Fun	noral	Home	РΔ				
	W.B.G	0110-		Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781								
	23. PART I. Enter the diseesea, or	complications that cau	aed the death. Do	not enter the m	ode of dving, auc	h aa cardiac or reani	ratory area	at	Approximate			
	shock, or heart failure.	List only one cause o						Interval Between				
	IMMEDIATE CAUSE (Final disease or condition)											
	reaulting in death)	a. >E	2/11/2									
1			AS A CONSEQUENCE O		2~				i			
N	Sequentially list conditions, b. MULTI INFARCT DEMINITA											
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR A	S A CONSEQUENCE O	IF):								
2	CAUSE (Disease or injury	с.										
# I	that initiated events resulting in death) LAST	DUE TO (OR A	S A CONSEQUENCE O	F):								
E		d										
2	PART II. Other aignificant condition	na contributing to deat	h but not reaulting	in the underlying	on cause given in	Pert I. 24s. WAS AN	AUTODSV	245 W	ERE AUTOPSY FINDINGS			
EDICAL		NSION			ig oddoc given in	PERFOR		A	MILABLE PRIOR TO			
ă	117/2016	1037010				1 YES 2	tino .	ő	OMPLETION OF CAUSE F DEATN?			
Σ						_		1	YES 2 AND			
	DID TODACCO LICE COLIT	RIBUTE TO CAUSE	OF DEATH Y	ES 🗌 NO [UNCERTAIN	1 🗆						
ž	DID TOBACCO USE CONT		25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one)									
CIAN	25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEA									
SICIAN		HOSPITAL:		OTHER:	ne 5 🗆 Residence	6 Other (Specify)						
HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/C	Outpatient 3 DOA	OTHER: 4 Printing No.	JURY AT	6 Other (Specify) 28d. DE\$CRIBE HOW II	NJURY OCCI	JRED				
Y PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	HOSPITAL:	Outpatient 3 DOA	OTHER: 4 D Aursing Note IE OF 28c. IN JURY W		11, 11, 17,	NJURY OCCI	JRED				
B	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	HOSPITAL: 1 Inpetient 2 ERV 28e. DATE OF INJU (Month, Day Yes) 28e. PLACE OF INJ	Outpatient 3 DOA 28b. Tili IN JRY — At home, farm,	OTHER: 4 B Aursing No. RE OF JURY W 1	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW II			te Number.			
ED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	HOSPITAL: 1 Inpetient 2 EP/C 28e. DATE OF INJUI	Outpatient 3 DOA 28b. Tili IN JRY — At home, farm,	OTHER: 4 B Aursing No. RE OF JURY W 1	JURY AT ORK? YES 2 NO	11, 11, 17,			te Number,			
ED BY	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined	HOSPITAL: 1 Inpatient 2 ER/C 28e. DATE OF INJUI (Month, Day, Ye) 28e. PLACE OF INJUI building, etc. (3)	Dutpetient 3 DOA 28b. Tile 174 JRY — At home, farm,	OTHER: 4 IP-Rursing No. IE OF 28c. IN URY M 1 atreet, factory, offi	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW II 28t. LOCATION (Street e City or Fown, State)	and Number o	or Rural Rou	te Number,			
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DIVISION OF VITAL RECORDS, P.O. BOX 68760. BALTIMORE, MARYLAND 21215-0020	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within mours after death. Page 6 may be retained by the hospital or attending physician.	
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral glirector, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	ges 1, 2, 3 should
IMPORTANT: if item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	

				F DEATH	MENTA	REG. NO.				
	. THURMAN J				MONT		1994	YEAR	6 a	
4. SOCIAL SECURITY NUMBER 218 28 2006	1 € M 2 🗆 F	GE (In yrs. lest birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS DAY		(Mont	OF BIRTH th, Day, Year) . 13,19		Countr	PLACE (State or Foreign	
90. FACILITY NAME (If not inetitution, give 10605 Graeloch R	n or location of d	EATH		Sc. COUN	ward					
nesidence of decedent 10a. STATE Maryland Ho	ry, town on Lo aurel	CATION					10d. INSIDE CITY			
10e. STREET AND NUMBER				10f. ZIP CODE			10g. CITIZ	EN OF W	1 YES 2 NO	
10605 Graeloch R	R IN U.S. ARMED	12 42 486	20723-2 DECENDENT OF HISPA				S.A.			
1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 Y	ES 2 NO	If yes,	specify Cuban, Mexic /ES 2 XNO Speci	en, Puerto	Rican, etc.)	or No-	Black	- American Indien, White, atc.	
15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	UCATION le completed) College (1-4 or 5+)	Iffe. Do NOT u	work done during ise retired.)	most of working	1135	. KIND OF BUS				
0-12		Maintena	ance, U	olumbia A				tena	nce	
17. FATHER'S NAME (First, Middle, Leet) William E. Thurm:	2.0			18. MOTHER'S N			Surname)			
19e. INFORMANT'S NAME (Type/Print)	ап	19b. MAILING	G ADDRESS (Stre	et and Number or Rural		eper	State, Zip	Code)		
Pauline L. Thurm	an	10605	Graelo	ch Rd.,La	urel.	Md. 2	0723	-221	2	
20a. METHOD OF DISPOSITION 1X Burlel 2 Cremellon 3 Ran 4 Donation 6 Other (Specify)	20b. PLACE AND DATE cometery, crematory or St. John	other place)	(Name of	DAT		i cott				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE St. John's 11-23 Ellicott City, Md.										
Harry H	· Witate								t City 21	
immediate cause (Fiber disease or condition resulting in death) but a static han Swall Cell lung Cencer Due to (or as a consequence of):								W	Onset and De	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
resulting in death) LAST	d					24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO			b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO	
PART II. Other aignificant condition	na contributing to deat	h but not resulting	in the underly	ring cause given in	Part I.	PERFORI	MED?	24b.	AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?	
PART II. Other aignificant condition	d	h but not resulting				PERFORI	MED?	24b.	AMARABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?	
PART II. Other aignificant condition	HOSPITAL:		28 OTHER:	ring cause given in	neck only o	PERFORI 1 YES 2	MED?	24b.	AMARABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?	
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PART II. Other aignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: 1 Inperient 2 ER/C 28e. DATE OF INJU (Month, Dey, Yee 28e. PLACE OF INJU building, etc. () BICIAN: To the best of my ke ER: On the bests of examin-	Dutpatient 3 DOA RY 29b. Till IN URY — At home, farm, Specify) nowledge, death occur ation and/or investigati	28 OTHER: 4 Nursing h AE OF JURY M 1 Street, factory, o	PLACE OF DEATH (CI lome 5 Residence INJURY AT WORK? YES 2 NO fffice late and place, and due 1, death occured at the 29c. LICENSE NU	6 Other	PERFORI 1 YES 2 IN (Specify) SCRIBE HOW IN CATION (Street ar or Town, State) use(a) and many a and place, and	JURY OCCI	URED or Rural R d. cause(a	AMALABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? 1 YES 2 NO Oute Number, and manner as stated (Month, Day, Year)	

BALTIMORE, MARYLAND 21215-0020	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physicia	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trope filed within 72 hours after death with the State Deat, of Health and Mental Hydiere prior to burial, cremation, or removal.	must be notified at once.
	te be executed within ours after death. Pag-	sician and completely filled in by the funeral dir- orior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	IAN: The law requires that the death certificat	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the the fled within 72 hours after death with the State Deat, of Health and Mental Hydiene prior to burial, cremation, or removal.	or item 23 shows any injury, or other
DIVISION OF	TO THE HOSPITAL OR ATTENDING PHYSICI	TO THE FUNERAL DIRECTOR: After this cen be filed within 72 hours after death with the	IMPORTANT: If Item 28 is marked, c

attending physician. se as the burial-transit permit. Pages 1, 2, 3 should

STATE	0F	MARYLAND	1	DEPARTMENT	0F	HEALTH	AND	MENTAL	HYGIE	NE
		C	E	RTIFICATE	0	F DEAT	H		REG. N	10.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last) John Alan Taylo	or				2. DATE OF DEATH MONTH DO NOV . 26		3. TIME OF DEATH 10:15 A M	
	4. SOCIAL SECURITY NUMBER 012-32-9895	1 X M 2 - F	52 YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) April 27,	1942 Ne	atthpLace (State or Foreign unity) W Hampshire	
TOR	96. FACILITY NAME (If not institution, give sti 4795 South Haven I		ott City		Howar				
DIRECTOR	10e. STATE 10b. COUNTY Maryland Howard			TOWN DR LOCAT	n DR LOCATION OTT City			10d. INSIDE CITY LIMITS7X 1 YES 2 ND	
FUNERAL	4795 South Haver	Drive		2.	ZIP CODE 1043		10g. CUIZEN O	WHAT COUNTRY?	
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES	2- NO	If yes, spe		NIC ORIGIN? (Specify Yea an, Puarto Rican, etc.) fy:	В	ACE — American Indian, lack, Whita, atc. pecifyWhite	
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	ATION completed) . College (1-4 or 5+)	16a. DECEDENT'S U (Give kind of wo life. Do NOT use Math. An	rk done during mos retired.)		Bendex	Corp.		
OM	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Melden	Sumame)		
BE C	Lester Taylor				Mafalda	Codespot	i		
TO B	19a. INFORMANT'S NAME (Type/Print) Mrs Susan Taylor		196. MAILING A 4795	SouthHa	nd Number or Rugal ven Driv	Route Munior City or Tow PELLICOTT	n, State Zip Code,	1043	
	20s. METHOD OF DISPOSITION 1		PLACE AND DATE OF DELETY, Cremetory or other altimore			DATE 200. LO	cation – chy or 27 Laur	al Maryland	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE . TI I to to		· Harry 4112	H Witzk Old Colu	te Funeral imbia Pike	Home In Ellicot	c. city 21043	
CERTIFICATION	shock, or heert failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A	ach line. CONSEDUENCE OF): CONSEDUENCE OF): CONSEDUENCE OF):		tasta	Lic.		Interval Between Onset and Daeth	
MEDICAL	PART II. Other aignificent conditions	contributing to deeth b	ut not resulting in	the underlying	; ceuse given in	Part I. 24a. WAS AN PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				ACE OF DEATH (C/	heck only one)			
YSIC	1 TES 2 NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Out		OTHER: Nursing Home	6 5 XResidence	8 Other (Specify)			
ву Рн	27. MANNER OF DEATH 1. Netural 5 Pending 2 Accident Investigation	28a. DATE DF INJURY (Month, Dey, Year)	28b. TIME INJU	RY WO	URY AT RK? 'ES 2 ND	28d. DESCRIBE HOW	NJURY OCCURED		
	3 Suicide 8 Could not be 4 Homicide determined	26a. PLACE OF INJURN building, etc. (Spe	28s. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify)			281, LOCATION (Street and Number or Rural Route Number, City or Town, State)			
COMPLETED	one) —	SAN: To the best of my known: R: On the basis of examination						e(s) and manner as stated.	
TO BE (296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU	MBER 39.	≥ 11/2 4	IED (Month, Dey, Weer)	
	30. NAME AND ADDRESS OF PERSON WHO			ounty G	èn Host	39.	duntia	, mD.	
	NOV 2 9 1994	82. REGISTRAR'S SIGN	Reveall	0	1514				

1 - FOR STATE REGISTRAR

OHMH-16 Rev t/89

1215-0020	hospital or attending physician.
BALTIMORE, MARYLAND 21215-0020	retained by the hospital
BALTIMORE,	ours after death. Page 6 may be
P.O. BOX 68760	certificate be executed within his

DIVISION OF VITAL RECORDS, P.O. BOX 68760.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours

	1	1. OECEOENT'S NAME (FIRST, MICHIELE A. TEMPLE		3. TIME OF DEATH
D		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 1 UNDER 1 YEAR IF UNDER 24 HRS. 7 YRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug. 6.1918	BIRTHPLACE (State or Foreign Country)
, 2, 3 should	ECTOR	90. FACILITY NAME (If not institution, give street and number) Dorchester Gen. Hospital Cambrid RESIDENCE OF DECEDENT		chester
it. Pages 1,	DIREC	Md, DORCHESTER 106. CITY, TOWN OR LOCATION A REY	Y	10d. INSIDE CITY LIMITS? 1 YES 2 NO
burial-transit permit.	FUNERAL	100. STREET AND NUMBER 4840 DRAWBRI doe Road 2186		N OF WHAT COUNTRY?
the	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEMENT EVER IN U.S. ABMED FORCES? 1 YES 2 MO II yes, specify Cuben, Mexican II YES 2 MO Specify	n, Puerto Rican, atc.)	Black, White, etc. Specify Black
ed for use as	PLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) CRADE 11 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mach DOMEST: C/4abaR	166. KINO OF BUSINESS/INDUS	
5 should be detached notified at once.	E COMPL		ME (First, Middle, Meiden Surname)	
age 5 should be notified	TO B	196. INFORMANT'S NAME (TyperPrint) ARdessa Pinder 4616 FARK Neck K	Rd. Viennoe, City or Town, State, Zip Co	.Md.21869
must		20a. METHOD OF DISPOSITION 1 Urburlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 20b. PLACE AND DATE OF DISPOSITION (Name of caretery, crematory or other pipe) ARE 22. NAME AND ADDRESS OF FAC	OATE 200. LOCATION - CH	
		- Janelle C. Henry 510 Washin	ieral Home	bridge Md
cremation, or removal.		23. PART Lenter the diseases, or complications that caused the wath. Do not enter the mode of dying, such shock, or heart feliura. List only one cause on each line. IMMEDIATE CAUSE (Fine) disease or condition as ARTCA-USCUCALOTIC CAILO (5)	La cardiec or reapiratory arrea	t, Approximete interval Between Onset and Death
3 6				
2 - 9		a. DUE TO (OR AS A CONSEQUENCE OF):	VIII GOOME 17.	YGAN
ysician and prior to bur traumati	CATION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING	VIII CONTO 17.	YCAN.
ending physician and I Hygiene prior to bu or other traumati	ERTIF	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):		YCAN
ed by the attending physician and th and Mental Hygiene prior to buu any Injury, or other traumati	L CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avante	Part i. 24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
een signed by the attending physician and of Health and Mertal Hygiene prior to buu shows any Injury, or other traumati	MEDICAL CERTIFI	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avante reauting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): The consequence of the consequ	Part i. 24a. WAS AN AUTOPSY PERFORMED? t □ YES 2 □ MO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
een signed by the attending physician and of Health and Mertal Hygiene prior to buu shows any Injury, or other traumati	MEDICAL CERTIFI	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avante reauting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSE	Part i. 24a. WAS AN AUTOPSY PERFORMED? t YES 2 No	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
een signed by the attending physician and of Health and Mertal Hygiene prior to buu shows any Injury, or other traumati	PHYSICIAN: MEDICAL CERTIFI	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avente reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONS	Part i. 24a. WAS AN AUTOPSY PERFORMED? t YES 2 No	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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AL DIRECTOR: After this certificate has been signed by the attending physician and 2 hours after death with the State Dept. of Heatth and Mental Hygiene prior to build them 28 is marked, or flem 23 shows any Injury, or other traumati.	MPLETED BY PHYSICIAN: MEDICAL CERTIFI	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avante reauting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSE	Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 D 1 YE	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AL DIRECTOR: After this certificate has been signed by the attending physician and 2 hours after death with the State Dept. of Heatth and Mental Hygiene prior to build them 28 is marked, or flem 23 shows any Injury, or other traumati.	BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avante reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONS	Part i. 24a, WAS AN AUTOPSY PERFORMED? 1 YES 2	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED Rural Route Number, seuse(a) and manner as stated.
een signed by the attending physician and of Health and Mertal Hygiene prior to buu shows any Injury, or other traumati	E COMPLETED BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated awante resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONS	Part i. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 DO 1 YES 2 DO 26d. DESCRIBE HOW INJURY OCCUI 28f. LOCATION (Street and Number or City or Town, State) 10 the cause(a) and manner as stated, time, data and place, and due to the cause (a) DATE S	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED Rural Route Number, cause(a) and manner as stated. BIGNED (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

Addition to certificate 12/2/94

Items 208 & 20c CARROLL Co. Wilm

1- FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH A

94 371

	HEGISTHAR		CE	CHILL	CALE	OF DEAL	н	R	EG. NO.		
- 8	1. DECEDENT'S NAME (First, Middle, Last)	-						2. DATE OF I	DEATH		3. TIME OF DEATH
1	Lois A. Titch	nena1					1	11 29) 1 C	94 YE	1635 M
- 9	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	l birthday)	IF UNDER 1 Y	EAR IF UNDER	24 HRS	7. DATE OF E			BIRTHPLACE (State or Foreign
- 13	263-22-1535	1 🗆 M 2 🔯 F	79	YRS.	MONTHS D	AYS HOURS	MIN.	2 2	y. Wear) 191		Country)
	9e. FACILITY NAME (If not institution, give a	22	19	1,10							lorida
~		,				WN OR LOCATIO		ATH	1	9c. COUNTY	OF OEATH
Ö	Carroll County	Genera:	l Hospi	tal	Wes	tminst	ter			Carr	011
2	RESIDENCE OF DECEDENT 10e. STATE 10e. COUNT										
DIRECTOR	Table 1			100	, TOWN OR I						10d. INSIDE CITY LIMITS?
		roll		Wes	stmin	ster					1 TYES 2 XNO
₹	10e. STREET AND NUMBER					10f. ZIP CODE			1	10g. CITIZEN	OF WHAT COUNTRY?
E	1234 Washington	n Rd.,				2115	57		I	Jnite	d States
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AR		13. WAS	DECENDENT OF	F HISPAN	IC ORIGIN? (S	pecify Yea or	No- 14.	RACE American Indian,
	1 Never Merried 2 Married	FORCES? 1	YES 2 N	10		s, specify Cuber YES 2 TVNO			n, atc.)		Black, White, atc. Specify:
BY	3 Widowed 4 Divorced				'-	X	ороспу				white
COMPLETED	15. DECEDENT'S EDU	CATION			USUAL OCCU			16b. KIN	ID OF BUSIN	ESS/INDUST	RY
<u> </u>	(Specify only highest grade	College (1-4 or 5	Hin	Do NOT us	rork done durli e retired.)	ng most of working	g				
4	12		·	orke	٩r			di	rv c1	Leane	rs
9	17. FATHER'S NAME (First, Middle, Last)					16. MOTH	ER'S NAI	ME (First, Middl			
	Claude Regina:	Id Pati	iff			Ada		Bus		····o····oy	
BE	19a. INFORMANT'S NAME (Type/Print)	La Raci.		MAIL IMO	ACCRECC (C	reet and Number					
임		_									<u></u>
	Cecilia Rohres					wood I	κα.,				
	1 Burial 2 Cremetion 3 Ram	oval from State	20b. PLACE A cemetery, cre					0ATE			or Town, Stata
	4 Donation 5 Other (Specify)		- Wester	EN M		CREMA			FRE.	DERICH	MD
	21. SIGNATURE OF FUNERAL SERVICE LIN	CENSEE				itts I			Hovao	s Ch	2201
14	Katherine	Disto	- Mi 27	511							minster, MD
	23. PART i. Enter the diseases, or	complications tha	t coused the de	ath. Do n	ot enter the	mode of dvi	na. such	ea cerdiec	or respirat	tory arrest	Approximats
	shock, or heart feilure.	List only one cau	ise on each line						о. тоориа.	tory arrost,	interval Between
	iMMEDIATE CAUSE (Final disease or condition		() ()	.00	126	0CV	4	(A	111	106	Onset and Death
ı	resulting in desth)	a	P1		114	1 00	/		((114	- FEW YR
		DUE TO	(OR AS X CONSEC	OUENCE OF): OH	VICC	an	1			mm
N	Sequentially list conditions,	b	1		1/1/1	120	10 11				I'mp c.
Ě	if any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CONSEC	DUENCE OF):						4000
길	CAUSE (Disease or Injury	C	100 to 1 000000								
E	that initiated eventa reaulting in deeth) LAST	DUE TO	(OR AS A CONSEC	DUENCE DE):						
CERTIFICATION		d									
	PART ii. Other significant condition	ns contributing to	death but not n	esulting i	n the unde	riving ceuse a	iven in	Pert I. 24e	. WAS AN AU	TOPSY	24b. WERE AUTOPSY FINDINGS
EDICAL									PERFORME	ED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
								10	YES 2	NO	DF DEATH?
Σ	DID TOBACCO USE	CONTRIBUT	E TO CAL	ICE A	E DEATH	I VEC E	1 17	5			1 TES 2 NO
PHYSICIAN:	DID TOBACCO USE	CONTRIBUT	E TO CAL	JOE OI	DEAH	1 153 [] NO	⁷ □			via
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	NOSPITAL:				6. PLACE OF DE	EATH (Che	ick only one)			1
S	1 YES 2 NO		ER/Outpatient 3	□ DOA	OTHER:	Home 5 - Res	sidence	6 Other (Sp	ecify)		
至	27. MANNER OF DEATH	28e. DATE OF (Month, D		28b. TIME		. INJURY AT WORK?		28d. DESCRI	BE HOW INJ	URY OCCURE	D
	Natural 5 Pending Investigation	(MORII, D	ay, reerj	INJ		YES 2	NO				Ì
ВУ	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE O	F INJURY At ho	me, ferm, s	treet, factory,	office		28t. LOCATIO	N (Street and	Number or R	Jural Route Number,
9	4 Homicide determined	bulloting,	atc. (Specify)					City or To	wn, State)		
Ē	29a. CERTIFIER , CERTIFYING PHYS	ICIAN: To the heat of	mu kasulatan 1		4		4 :				
₩ I		ICIAN: To the best of									
COMPL		>	AMINIMINAL BUILDING	vesigatio	i, in my opin	on, death occur	ed at the	time, data and	place, and c	oue to the ce	use(a) and manner as stated.
ш	296. SIGNATURE AND TITLE OF CENTIFIE	2	DIL	19		29c. LICE	NSE NUM	BER //	2	9d. DATE SIG	GNED (Month, Day, Year)
TO B		VY	300			100	192	146		MIC3	3094
F	DO. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAU	SE OF DEATH (ITE	27) (Type,	Pript)	111	1	1 11	1.	1	1/10
	NIKHNIA 6	1760	Shinit	on	ngt	Med	CA	7 111:	MINTE	2 ster	Ma21157
1	31. DATE FILEO (Month, Day, Year)	32 AEGISTRA	R'S SIGNATURE	,	1		011	- 11	97-01/	1 17 "	
- 11	117-1:(1-1-100	/1 C/1, // . A	5 0								

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DIVISION OF VITAL	
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to buriat, cremation, or removal.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	BEG NO

1 - FOR STATE REGISTRAR		STATE OF MARY			OF HEALTH A		AL HYGIEN		
1. DECEDENT'S NAME	(First, Middle, Last)					_	E OF DEATH		3. TIME OF DEATH
	CE G. T							6, 1994	
148-18	-6043	1 🗆 M 2 💢 F	(In yrs. lest birthday)	IF UNDER 1			e of BIRTH	8. Bi	PA .
911. FACILITY NAME (III	IN NURS	SING HOME		9b. CITY,	BERLIN	OF DEATH		9c. COUNTY O	F DEATH CESTER
BERL RESIDENCE OF 100. STATE	10b. COUNT	V Vorcester	10c. C()	Y, TOWN OF	LOCATION N				10d, INSIDE CITY LIMITS?
					101. ZIP CODE 218	11			I VES 2 (NO
11. MARITAL STATUS		12. WAS DECEDENT EVER FORCES? 1 YE	S 2 NO		MS DECENDENT OF H	IISPANIC ORIG		or No.— 14, R	ACE — American Indian, lack, White, etc.
3 Widowed 4		IF YES, GIVE WAR OR	DATES 16a. DECEDENT'S		YES 2 NO		L VINO OF BUIL	SINESS/INDUSTR	WHITE
Elementary/Second 12 17. FATHER'S NAME (F)	fy only highest grade	e completed) College (1-4 or 5+)	(Give kind of life. Do NOT u	work done du se retired.)	uring most of working		Own I		*
17. FATHER'S NAME (F)) R S				LLIAN	Middle, Malden	Surname) ARRISO	N
198. INFORMANT'S NA	ME (Type/Print) IAN ERN	IEST	195. MAILING 1142	ADDRESS 8 QU	(Street and Number pr	A T B	mber, City or Tow ERLIN	n, State Zip Code	21811
20a. METHOD OF DISP 1 Surial 2 Cre 4 Donation 5	mation 3 Rem		Db. PLACE AND DATE emetery, crematory or c	ther place)		1	TE 20c. LO	CATION — City o	
21. SIGNATURE OF FU		CENSE	CEDAR	22. N	AME AND ADDRESS	OF FACILITY			RLIN, MD.,
immediate cause disease or condition resulting in death)	or neert failure.		A CONSEQUENCE O	2 /:		4 5	1,100	2 4	Interval Between Onset and Death
Sequentially list or if any, leading to it cause. Enter UNDE CAUSE (Disease Dithat initiated event resulting in death)	mmediate RLYING injury	a diff	A CONSEQUENCE O	7114	Enrese	1200.	.,,		1/1
25. WAS CASE REFERE EXAMINER? 1 YES 2 N 27. MANNER OF DEATH	ificant condition	na contributing to death	but not resulting	in the unc	leriying ceuse give	en in Part i.	24a. WAS AN PERFOR 1 YES 2	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
25. WAS CASE REFERE	ED TO MEDICAL				26. PLACE OF DEAT	TH (Check only	one)		
1 ☐ YES 2 ₩ N)	HOSPITAL: 1 Inpatient 2 I ER/Ou	ripatient 3 DOA	OTHER	: ng Home 5 ☐ Rasid	enca 8 🗆 Ott	ner (Specify)		
27. MANNER OF DEATH	_	28a. DATE OF INJURY (Month, Day, Yeer,		IE OF	28c. INJURY AT WORK?	28d. D	EŞCRIBE HOW I	NJURY OCCURE	
1 X Netural 2 Accident	5 Pending Investigation			M	1 YES 2 N	10			
	Could not be determined	28e. PLACE OF INJUI building, etc. (Sp	RY — At home, farm, pecify)	street, facto	ry, offica		CATION (Street of yor Town, State)	and Number or Ru	rai Route Number,
		SICIAN: To the best of my kno ER: On the bests of examinat							se(a) and manner as stated.
					29c. LICENS				NED (Month, Day, Year)
o l	1200	2222	7			2026			· 2 6 6 4
30. NAME AND ADDRE		nes, MD 162	DEATH (ITEM 27) (Type				. 21811		-641-6363
Maria and a second		32. REGISTRAR'S SIG	INATURE						
4 31. DATE FILED (Month,	29 199	4 Julia Dan	ison-Randal	L.					

B.K.S ITEM: 23 PART I, 27, PER MED FILM G-718 12/30/94 t.t. amonded etem # 7, 12/2/94, Hoursond County, S.B.

37113 94

1	-	FOR STATE REGISTR	ΑR
1 1	. D	ECEDENT'S	NA

	STATE REGISTRAR				CERTIFI	CATE (OF DEATH		REG. NO.			
1. DI	ECEDENT'S NAME (First	Middle, Last)						2. DA	TE OF DEATH	_		3. TIME OF DEATH
4. Sc	JOYCE	NER	Y.		IOMAS	IF UNDER 1 YE	AR IF UNDER 24	DE	EC. 1		94	5:00 A m
	37-08-038		1 M 2 TF	3				IIN. (Mc	nth, Day, Year)	961	B. BIRTHP Country)	
	FACILITY NAME (If not in	0	21		3	9b. CITY, TO	WN OR LOCATION		t. 31,	199	NTY OF DE	LA
RE	FALLSTON SIDENCE OF DEC	HOSPI	TAL				LSTON				RFOF	
	STATE	10b. COUNTY			10c. CITY	, TOWN OR L	OCATION	-				IOd. INSIDE CITY
	MD	Harf	ord		Edg	gewoo	d					LIMITS?
	STREET AND NUMBER				_		101. ZIP CODE			10g. CITI	ZEN OF WI	AT COUNTRY?
_	951-A Ed						210	10			1	JSA
	MARITAL STATUS Never Merried 2		12. WAS DECEOEN FORCES? 1	YES 2	X MO	13. WAS	DECENDENT OF H	ISPANIC ORIG	GIN? (Specify Yes o Rican, etc.)	or No-	14. RACE - Black,	- American Indian, White, atc.
11	Widowed 4 Divo		IF YES, GIVE W	AR OR DATES		1 🛮	YES XIXNO	Specify:	,		Specify	Black
	15. OEC	EDENT'S EDUC	ATION	16:	. DECEDENT'S	USUAL OCCU	PATION	1	6b. KIND OF BUS	INESS/INC	USTRY	
-	(Specify onl) Elementary/Secondary (0	highest grade c	College (1-4 or 5 +	,	(Give kind of w life. Do NOT use	rork done durin e retired.)	g most of working					
	12		1		fuel	hand	ler		U.S. A	rmy	Res	erves
	ATHER'S NAME (First, M								, Middle, Maiden	Surname)		
<u> </u>	harlie T			-				a Col				
	INFORMANT'S NAME (7)	1120 000					reet and Number or					21010
-	RLA CLEM						ester (- 1				
10	Burlal 2 Cremation	n 3 🗆 Ramos	al from State	20b. PL	CEAND DATE O	her place)	at'l Ce	m 10	TE 20c. LO	CATION —	City or Tow	n, Stata
	DONATURE OF FUNEBAL		MSEE /	FOI	c maas	22. NAN	E AND ADDRESS	DE ENCILITY	-/ Por	t HI	ldsoi	
	Vh. 1.	1//	//./	/			ard Fur			-		21078
00	mence	- ca	100				2 Lewis					ce, MD
iMM	PART I. Enter the di shock, or he MEDIATE CAUSE (Fin ease or condition ulting in death)	eart failure. Li	MYOCARD I	AL INF	ARCT	_	mode of dying	such as ca	irdiac or reapi	retory arr	est,	Approximate interval Between Onset and Death
					NSEQUENCE OF):						
	quentially list conditi				SUSIS							
Cau	ny, leading to immediae. Enter UNDERLYi	NG		CLEROTIC CARDIOVASCULAR DISEASE								į
that	USE (Disease or inju t initiated events	'y			A CONSEQUENCE OF):							
rest	uiting in death) LAS	T d.										
PAR	T ii. Other significa	nt conditions	contributing to	death but r	ot resulting in	n the under	lying cause give	n in Part i.	24a. WAS AN PERFOR	MED?	1 6	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE
H											1 '	F DEATH?
											1	YES 2 NO
D	DID TOBACCO U	SE CONTRI	BUTE TO CA	USE OF D	EATH YES	S NO	☐ UNCER	TAIN			1	YES 2 NO
25. W	WAS CASE REFERRED TO EXAMINER?	MEDICAL			LACE OF DEATI	H (Check only		TAIN 🗆			1	YES 2 NO
25. W	NAS CASE REFERRED TO EXAMINER? XXYES 2 NO	MEDICAL	HOSPITAL:	28, I ER/Outpetier	PLACE OF DEATI	H (Check only OTHER:			her (Specify)		1	YES 2 NO
25. W E 27. M	MAS CASE REFERRED TO EXAMINER? XYES 2 NO MANNER OF DEATH	MEDICAL	HOSPITAL:	28. I ER/Outpaties	PLACE OF DEATI	OTHER: 4 Nursing OF 28c	one)	enca 6 🗆 Oti	her (Specify) ESCRIBE HOW IN	HURY OCC		YES 2 NO
25. W E 27. M 1X 2	WAS CASE REFERRED TO EXAMINER? X YES 2 NO IANNER OF DEATH X Natural Accident Suicide 8	O MEDICAL Pending	HOSPITAL: 1 Inpatient 2X 28s. OATE OF (Month, De	28, I ER/Outpatier INJURY ny, Year)	R 3 DOA	OTHER: 4 Nursing OF 280 JRY M 1	Home 5 Raside INJURY AT WORK? YES 2 N	28d. 0			CUREO	
25. W E 27. M 1X 2 3 4	NAS CASE REFERRED TO EXAMINER? X YYES 2 NO IANNER OF DEATH Accident Suicide Homicide CERTIFIER Check only 1 CERT	Pending nivestigation Could not be setarmined	HOSPITAL: Inpetiant 2X 28a. OATE OF (Month, De 28a. PLACE Of building, AN: To the best of	ER/Outpetler INJURY y, Year) F thJURY — A atc. (Specify)	28b. Time INJU	OTHER: 4 Nursing OF 28c RY M 1 Ireet, factory,	Home 5 Reside. INJURY AT WORK? YES 2 N	28d. 0 28t. LC	ESCRIBE HOW IN CATION (Street a y or Town, State) ause(s) and man	nd Number	or Rural Ros	ite Number,
25. W E Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z Z	NAS CASE REFERRED TO EXAMINER? X YYES 2 NO AANNER OF DEATH Netural Accident Suicide Homicide CERTIFIER (Check only one) 2 X NEO	Pending investigation Could not be letarmined	HOSPITAL: Inpetiant 2X 28a. OATE OF (Month, De 28a. PLACE Of building, AN: To the best of	ER/Outpetler INJURY y, Year) F thJURY — A atc. (Specify)	28b. Time INJU	OTHER: 4 Nursing OF 28c RY M 1 Ireet, factory,	Home 5 Reside	28d. 0 28t. LC Ch	ESCRIBE HOW IN CATION (Street a y or Town, State) ause(s) and man	nd Number	or Rural Roo	ite Number,
25. W E 27. M 1 1 1 2 2 3 4 4 1 2 2 4 1 2 2 4 1 2 2 4 1 2 2 4 1 2 2 4 1 2 2 4 1 2 4	NAS CASE REFERRED TO EXAMINER? YEYES 2 NO IANNER OF DEATH Accident Suleide Homicide CERTIFIER (Check only one) SIGNATURE AND TITLE	Pending investigation Could not be betarmined IFYING PHYSICI CAL EXAMINER:	HOSPITAL: Inpetient 2X 28s. OATE OF (Month, De 28s. PLACE Of building, AN: To the best of on the basis of ax	28. I ER/Outpetler INJURY y, Year) F INJURY — A atc. (Specify) my knowledge amination and	PLACE OF DEATI 3 DOA 28b. TiME 1 home, tarm, at a, dasth occurred/or investigation	M (Check only OTHER: 4 Nursing OF 28c PRY M 1 Irrest, factory, d at the time, n, in my opinion	Home 5 Reside. INJURY AT WORK? YES 2 N	28d. 0 28t. LC Ch d dua to the c at the tima, da	ESCRIBE HOW IN CATION (Street a y or Town, State) ause(s) and man	nd Number ner as stat d due to th	or Rural Rod ed. e cause(s) (E SIGNED (I	ite Number,
25. W E 3 27. M 1 1 2 1 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1	NAS CASE REFERRED TO EXAMINER? VEYES 2 NO IANNER OF DEATH Accident Suleide Homicide CERTIFIER (Check only one) SIGNATURE AND TITLE	Pending investigation Could not be betarmined IFYING PHYSICI CAL EXAMINER:	HOSPITAL: Inpetient 2X 28s. OATE OF (Month, De 28s. PLACE Of building, AN: To the best of on the basis of ax	28. I ER/Outpetier INJURY F INJURY — A stc. (Specify) my knowledge amination and E OF DEATH	PLACE OF DEATI 1 3 DOA 28b. TIME 28b. TIME 1 home, term, et 2 home, term, et 2 home, term, et 2 home, term, et 3 DOA 2 home, term, et 4 home, term, et	OTHER: 4 Nursing OFHER: 4 Nursing OFHER: 4 Second of the time, in, in my opinion Print)	Home 5 Reside NJURY AT WORK? YES 2 N office deta and place, an on, death occurred a	28d. 00 28t. LC CA d due to the cat the time, de	OCATION (Street a y or Town, State) suse(s) and man ta and place, and	nd Number	or Rural Root ed. cause(s) (i E SIGNED (i	ite Number, and manner as stated. Ronth, Day, Year)

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

31. OATE FILEO (Month, Day, Year)
DEC 0 2

32. REGISTRAR'S SIGNATURE

iours after death. Page 6 may be retained by the hospital or attending physician. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 687604 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
REGISTRAR

CERTIFICATE OF DEATH
REG NO

	REGISTRAR	CERTIFIC	CATE OF	DEATH	REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3.	TIME OF DEATH
	Kare Taux (1) ETI TOI	RA ROSE TAM	RIIRA		MONTH D	6	YEAR	8, 25 04
			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN		9.9	ACE (State or Foreign
	215-05-6643 1□M2፟MF 8!		ONTHS DAYS	HOURS MIN.	July 25, 1	000	Country)	1
	0.					7	Ital	4
Or.	9a. FACILITY NAME (If not institution, give street and number)	9		OR LOCATION OF DEA	ATN	9c. COUN	TY OF DEAT	Н
ē l	Sinai Hospital		Balt	imore				
ត្ត	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c CITY	TOWN OR LOCA	TION .			1.0	
Ē								d. INSIDE CITY LIMITS?
٦		we	stmins					YES 2 X NO
⊼ੂ∣	10e. STREET AND NUMBER		10	I. ZIP COOE		10g. CITIZ	EN OF WHAT	T COUNTRY?
Ÿ.	3810 Wine Road			21158		U.	S.A.	
FUNERAL DIRECTOR	11. MARITAL STATUS 12. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED	13. WAS DEC	ENDENT OF HISPANI	C ORIGIN? (Specify Yes	or No-	14. RACE — Black, W	American Indian,
BY	1 Never Married 2 Married FORCES? 1 YES 3 Wildowed 4 Olvorced FORCES? 1 YES		1 YES	ecify Cuban, Maxican, 2 NO Specify:	, Puarto Hican, etc.)		Specify:	1
	3 Wildowed 4 Olvorced					- 1		White
岜!	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind of wor	k done durina ma	ON set of working	16b. KIND OF BU	SINESS/INDU	JSTRY	
91	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use r	etired.)	or or money				
4	8	_Seamst:	ress		Clothi	ng M	lfg.	
COMPLETED	17. FATNER'S NAME (First, Middle, Last)			18. MOTNER'S NAM	E (First, Middle, Maiden	Sumame) R(OSA GUE	GLIITZZA
BE	Francis Tamburo			Rosa	- (Unkr	lown)	-	
	19a. INFORMANT'S NAME (Type/Print)	19b. MAILING AL	ODRESS (Street a	and Number or Rural Ro	oute Number, City or Tow	n, State, Zip (Code)	
임	Frances R. Palazzolo				stminste			158
	20a, METHOD OF DISPOSITION 1 & Burial 2 Cremation 3 Removal from State came	PLACE AND DATE OF					Olty or Town,	
	1 Ø Buriel 2 Cremation 3 Removal from State	w Cathedi	place)	Dec	: O		re,	
ı	21. SIGNATUME OF FUNERAL SERVICE LICENSES	w caranean		ND ADDRESS OF FACI	994 243	CIMO	,10,	TID
- 1	· (\X)/X \		J.J.	Hartens	tein Mor	tuar	v. Tr	nc.
_	for Harlenstein		24 S	econd St.	tein Mor	eedon	ń, PA	17349
	23. PART//Enter the diseases, or complications that caused	the death. Do not	enter the mo	de of dying, such	ss cardiac or reapi	ratory srre	at,	Approximeta
	shook, or heart fallure. List only one cause on each immediate cause (Final	ch line.						Interval Between Onset and Daath
	disesse or condition						1	10
ŀ	rasulting in desth) s. Due to (on as a c	CONSEQUENCE OF):						102.
_	- Uliver	Tand	Till	a + im .				
CERTIFICATION	Sequentially list conditions, Due to ion as a s	ONSEQUENCE OF	-NK	MOIL				wells.
A I	if any, leading to immediate csuse. Enter UNDERLYING	12- 1/2	1000	2				1100
윤ᆘ	CAUSE (Disease or injury	CONSEQUENCE OF	Anni	C			_	412-
	that initiated eventa reaulting in death) LAST						j	
	C d				124		_	
ا د	PART II. Other significant conditions contributing to death but	t not reaulting in	the underlyin	g cause given in P	Part I, 24s, WAS AN	AUTOPSY		RE AUTOPSY FINDINGS
S	- 20				PERFOR			MPLETION OF CAUSE
		***			1 YES 2	X) NO		DEATN?
Σ	DID TORACCO LICE CONTRIBUTE TO CALICE OF	DEATH VEC		1			1 1	YES 2 NO
¥	DID TOBACCO USE CONTRIBUTE TO CAUSE OF 25. WAS CASE REFERRED TO MEDICAL 2			UNCERTAIN	DKJ			
HYSICIAN:	EXAMINER? HOSPITAL:	8. PLACE OF OEATN	THER:					
\Z	1 PYES 2 PYO(() 1 Inpettent 2 ER/Outpet	lent 3 DOA 4	☐ Nursing Hom	e 5 🗆 Rasidence 6	Other (Specify)			
표	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year)	286. TIME C	F 28c. INJ	URY AT	28d. OEŞCRIBE HOW II	NJURY OCCU	JRED	
<u> </u>	1 Netural 5 Pending 2 Accident Investigation		M 1	rES 2 NO				
	3 Suicide 6 Could not be 26a. PLACE OF INJURY - building, atc. (Specify	At home, farm, stre	et, factory, offic		261. LOCATION (Street a City or Town, State)	ind Number o	r Rural Route	Number,
<u>" </u>	4 Homicide detarmined				0.1, 0. 1011., 0.010,			
Ž	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowled	dge, death occurred a	t the time, date	and place, and due to	the cause(a) and mad	nor so state.	4	
COMPLET	one) 2 MEDICAL EXAMINER: On the beels of examination							d manner as stated
	29b. SIGNATURE AND ATLE OF CERTIFIER							
쀪	16.00 Salara 144	n Al		29c. LICENSE NUMB	SEH 1	29d, DATE	SIGNEO (Moi	nth, Day, Year)
2 ∦	30, NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEAT	M-HVA.	rician	40	104		201	94
	30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEAT	N (ITEM 27) (Type, Pri	1 1	D- 14	1110 -			
	Edith July May Jina	1 10050	ital	noit	MU 2	1215		
	31. DATE FILEO (Month, Dey, Year) 32. REGISTRAR'S SIGNAT DEC 1 2. 1004	TURE	.)					
	DEC 1 2 1994 White Daniellan Nand	all						

BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	e medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an income after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the for befield within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

DIVISION OF VITAL RECORDS,

FOR

	1 - STATE REGISTRAR	SIAIE UF N	IANTLAND / CE	RTIF	ICATI	F OF	DEAT	AND I	MENTAL HYGIENI REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Lest)				107111		DEA		2. DATE OF DEATN		T:	3. TIME OF DEATN
	EMILY HIVLING	TROUP	F						NOVEMBER 2		YEAR	
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs. last	birthday)	IF UNDER	R I YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTN	0 19	6. BIRTHPI	3:13 A M
	214-09-1372	1 🗆 M 2 🕢 F	92	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year) _7/05/1902		Country)	
	9e. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY	r, TOWN C	R LOCATION	ON OF DE			Mary	Land
8	Homewood Nursing I	Home			10/: 1	Lion		_				
5	Homewood Nursing Home Williamsport RESIDENCE OF DECEDENT								wası	hingt	on	
🖺	10a. STATE 10b. COUNTY			10c. CIT	Y, TOWN	OR LOCAT	ION				1	IOd. INSIDE CITY LIMITS?
	Maryland Washington			Wi	Шia	mspo		_				YES 2 NO
RA	Control Control					101	. ZIP CODI	E		10g. CITIZ	ZEN OF WH	AT COUNTRY?
BY FUNERAL DIRECTOR	16505 Virginia Ave	2.	T EVER IN U.S. ARM	450	1 40		2179			Щ		
교	1 X Never Married 2 Married	FORCES? 1	YES 2 X NO	O		If yes, spe	ecify Cuba	n, Mexice	HC ORIGIN? (Specify Yea n, Puarto Rican, etc.)	or No-		- American Indian, White, atc.
	33 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		_	1 YES	2 □XHO	Specify	y:	- 1	Specify:	White
8	15. DECEDENT'S EDUC (Specify only highest grade	CATION Completed				CCUPATIO			16b. KIND OF BUS	INESS/IND		
4	Elementary/Secondary (0-12)	College (1-4 or 5	Ma	Do NOT u	se retired.)	auring mo	st of workin	g				
<u>Ā</u>	. 12		Ret	ired	Cle	rk			Western	Md.	Railu	121/
COMPLETED	17. FATNER'S NAME (First, Middle, Last)	-					18. MOTI	HER'S NA	ME (First, Middle, Malden	Sumame)		
BE	William Fdgar Tro	опре							Hivling Se			
2									Route Number, City or Town			
	Dorothy Seibert							. CI	ear Spring			
	20a. METNOD OF DISPOSITION 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Rame	ovel from State	20b. PLACE A	ND DATE	of DISPOS ther place)	SITION (Na	me of				City or Town	
	4 Donation 5 Other (Specify)	INSER 1	St. Pa	auls			ID ADDRE	1	1/29/94 Clear	Spri	ng. Mc	. 21722
	-///	7/1										
	11/1/20 1/11	- Vom	_	_	Ρ.	0. Bo	× 310	Clea	Home, Inc. or Spring, Md.	2172	2	
	23. PART I. Enter the disesses, or c shock, Dr heart fallure. I	omplications the	t caused the des	th. Do	not enter	the mo	de of dyi	ng, sucl	h as cardiac or respli	ratory srr	est,	Approximate interval Between
	IMMEDIATE CAUSE (Finsi	,,	, /									Onset and Death
	disease or condition resulting in death)	3,	14916	266	E							
		DUE TO	(OR AS A PONSEO	UENICE O	F):	1	//	01				
NO	Sequentially list conditions,	DIJE TO	OR AS A CONSEC	746		EN,	els	Con	u,			
CERTIFICATION	if sny, leading to immediate cause. Enter UNDERLYING	DOE 10	ON AS A CONSEC	UEBCE U	r);							
윤	CAUSE (Disesse or injury that initiated events	DUE TO	(OR AS A CONSEO	UENCE O	F):							
토	resulting in death) LAST											
MEDICAL	PART II. Other significant conditions	s contributing to	death but not re	sulting	in the u	nderlying	g cause g	given in	Part I. 24s. WAS AN . PERFOR			VERE AUTOPSY FINDINGS
Ö									1 YES 2	-NO		COMPLETION OF CAUSE OF DEATH?
									_		1	YES 2 NO
ä												
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHE		ACE OF D	EATH (Che	eck only one)			
IYS	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 28a. DATE OF	ER/Outpetient 3		4 B Nu	raing Nom		sidenca	6 Other (Specify)			
	1 Natural 5 Pending	(Month, D		28b. TIN	URY M		URY AT RK7 (ES 2	7 NO	28d. DESCRIBE HOW IN	IJURY OCC	CURED	
BY	2 Accident Investigation	28e PLACE O	F INJURY — At hon	ne form	etraat fan			J NO	28f. LOCATION (Street a	and 61	0	Al-
GB.	3 Suicide 8 Could not be 4 Homicide detarmined	building,	atc. (Specify)	ne, revin,	anser, 160	tory, orner			City or Town, State)	na Number	or Hunar Hot	ute Number,
	29a. CERTIFIER											
COMPLETED	(Check only one) 1 CERTIFYING PNYSIC One) 2 MEDICAL EXAMINITY											Harry Harrison
8				weatigatio	on, in my i	opinion, u	emin occur	ed at the	time, data and place, and			
BE	296. SIGNATURE AND TITLE OF CERTIFIER	111					290 110	NSE NUN	ABER CON	29d. DATE	SIGNED (Month, Day, Year)
2	30. HAME AND ADDRESSOR PERSON WHO	COMPLETED CALL	SE OF DEATH OTHER	27) (5	Original		1	6	100	-/	1/2.	0/17
	HIDALAD	747	North	on	Th	e l	Yes	EB.	Laun	D	21	742
	NOV 3 0 1994		R'S SIGNATURE	المالية			1					
	1101 - 1004	0	1									

BALTIMORE, MARYLAND 21215-0020
fifer death. Page 6 may be retained by the hospital or attending physician.
The funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

REG. NO.

	REGISTRAR	CERTIFIC	CATE OF	DEATH	REG. NO				
	1. DECEOENT'S NAME (First, Middle, Last) DRUCILLA	A. T	RICE		OCT 31	^{AY} 1994 ^{AR}	3. TIME OF DEATH 12:38 P M		
	217-01-4941 1 M 2 DVF		IF UNDER t YEAR MONTHS DAYE	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 0 5 / 0 9 / 1	Cou	THPLACE (State or Foreign intry)		
DIRECTOR	9e. FACILITY NAME (If not institution, give street and number) Memorial Hospital of East RESIDENCE OF DECEDENT		96. CITY, TOWN O East	R LOCATION OF DE	ATH	9c. COUNTY OF			
l D	10e. STATE 10b. COUNTY	10a CITY	TOWN OR LOCATI	ION					
	Maryland Caroline	100.011,		Fede	ralsburg		10d. INSIDE CITY LIMITS? 1 YES 2 1 NO		
FUNERAL	28055 Bloomery Road		107.	ZIP CODE 2	1632		d States		
В	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Nyldowed 4 Divorced 12. Was DECEDENT EVER FORCES? 1 YES, GIVE WAR OR	If yea, spe	S DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— se, specify Cuben, Maxican, Puerto Rican, etc.) YES 2 X NO Specify: Whispanic Specify: White Specify: White Spec						
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	18e. OECEDENT'S U (Give kind of wo life. Do NOT use Manufa	ork done during mos retired.)	t of working	2, 25, 25, 25, 25, 25	astics			
Σ	12th	Manuia	CLULINE	š	-				
ВЕ СО	17. FATHER'S NAME (First, Middle, Last) Charles F.	n Sumame)							
10	19a Informant's Name (Type/Print) T. Diane Hudson	Rt.	3, Box	134 F,	oute Number, City or Tow Bridgev	ille,	DE 19933		
	1) Buriel 2 Cremetion 3 Removal from State	Ob. PLACE AND DATE OF emetery, crematory or other Eastern	er place)		Hu	cation - city or 110ck,	Town, State Maryland		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		Fram;	o A O O M - H a	wkins-Es		neral Home		
Щ	THOOLIGHT GOVERN				Federals		MD 21632		
	23. PART i. Enter the disease, or complicatione that cause ehock, or heert failure. List only one ceuse on iMMEDIATE CAUSE (Finei disease or condition	eech iine.			es cardlec or reapl	ratory arrest,	Approximate intervei Between Onset end Death		
	e. Venue and the state of the s								
CERTIFICATION	Sequentielly list conditione, if any, leeding to immediate ceuse. Enter UNDERLYING								
TIFIC	CAUSE (Disease or Injury that Initiated evente resulting in deeth) LAST	A CONSECUENCE OF:	2/08/1	nux Du s	200 00				
핑	d. Co 207 Cd	3	dury		eene		-		
	PART II. Other eignificent conditions contributing to death		0	. //	PERFOR		4b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO		
EDICAL	Complete Heart Block		elto	rilyre	1 YES 2		COMPLETION OF CAUSE OF DEATH?		
뿔	Diabetes Mellitus Co	relevovasa	ulas	Diseas	4		1 YES 2 NO		
	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YES	□ NO ☑	UNCERTAIN					
₹	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	28. PLACE OF DEATH							
S	1 YES 2 NO 1 Inpatient 2 ER/Ou		OTHER: I Nursing Homa	5 - Residence	B C Other (Specify)				
BY PHYSICIAN:	27. MANNER OF DEATH 1 Natural 5 Pending (Month, Dey, Year) 2 Accident Investigation	28b. TIME INJUI	RY WOR		28d. OEŞCRIBE HOW I	NJURY OCCURED			
	I Pacificant	RY — At home, ferm, atrecify)	eet, factory, office		28f. LOCATION (Street a City or Town, State)	and Number or Rura	l Route Number,		
J.E	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the beet of my kno	wiedge, deeth occurred	at the time, date of	and place, and due t	to the cause(a) and mar	oner as stated			
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: On the basis of examinating						e(a) and manner as stated.		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER MC J Ku & Lind M D	FACE	/	29c. LICENSE NUM	BER	29d. OATE SIGNI	ED (Month, Day, Year)		
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF D	EATH (ITEM 27) (Type, P	Print)			10/2	1144		
	21 OATE Ell ED (Month Day Wast)	MATURE				-			
	31. OATE FILED (Month, Day, Year) NOV 0 2 94 Suna Daydoo	n-Mandell							

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and long ster death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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	FOR 1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH		3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	Vance	Taylor	-			28, 1994			
	217-54-9183	5. SEX 6. AGE (IF UNDER 1 YEAR KONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan 20,	Count			
	9a. FACILITY NAME (If not institution, give str	144		Db. CITY, TOWN O	R LOCATION OF DE		9c. COUNTY OF	eland DEATH		
DIRECTOR	Longview Nursing H	Iome		Manc	nester		Carro	11		
REC	10a. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCAT	ON			10d. INSIDE CITY LIMITS?		
	Maryland C	Carroll	W	estmins				1 ½ YES 2 □ NO		
FUNERAL	30 Locust Street,	Nnt 608		101.	21157		10g. CITIZEN OF			
	11. MARITAL STATUS	12. WAS DECEDENT EVER II			NDENT OF HISPAN	IIC ORIGIN? (Specify Yes	or No- 14. RAC	States E - American Indian,		
BYF	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES			2 NO Specify	n, Puarto Rican, atc.)	Spec			
	15. DECEDENT'S EOUC. (Specify only highest grade of	ATION	16a. DECEDENT'S U	SUAL OCCUPATION	N	16b. KIND OF BU	SINESS/INDUSTRY	ite		
COMPLETED	Elamentary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use		t of working					
MP	17. FATHER'S NAME (First, Middle, Lest)		Proc	essor	46 MOTHER'S MAI	BC:OK ME (First, Middle, Maiden	Distrib	ution		
	Thomas Alexander V	ance				Mabel McM				
O BE	19a, INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street a		Route Number, City or Tow				
	Alice T. Dutterer	1				minster, M				
	20a, METHOD OF DISPOSITION 1 2 Burial 2 Cremation 3 Remo 4 Donation 5 Other (Specify)	val from State Cen	n. PLACE AND DATE OF the tery, cremetory or othe CETGIEEN	er place)			CATION — City or T			
	21. SIGNATURE OF FUNERAL SERVICE LICE		vergreen i	22, NAME AN	D ADDRESS OF FA	CILITY	nksburg,	Maryland		
	THIRMAN	1) a host	HINON		Funeral	l Home <u>ceet, West</u>	minetor	MD 21157		
	23. PART I. Enter the diseases, or co ahock, or heart failura. L	omplications that ceval	the death. Do no	t enter tha mo	da of dying, auci	h as cardiac or reap	ratory arreat,	Approximata interval Between		
	IMMEDIATE CAUSE (Final disease or condition	0	~ ~		4.4	CP.		Onset and Death		
	resulting in death)	DUE TO (OR AS A CONSIDUENCE OF)								
2	Sequentially list conditions,	a letal failure works								
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF):							
E	CAUSE (Disease or injury that initiated events	DUE TO (OR AS /	CONSEQUENCE OF):							
E E	resulting in death) LAST	,								
AL	PART II. Other significant conditions	contributing to death b	out not reaulting in	tha underlying	ceuse given in	Part I. 24a. WAS AN		. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
EDIC						1 🗆 YES 2	! □ NO	COMPLETION OF CAUSE DF DEATH?		
Σ	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF	DEATH	YES NO	<u> </u>	1	1 YES 2 NO		
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			ACE OF DEATH (Che	eck only one)				
HYSI	1 VES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outp	ontient 3 DOA 1			6 Other (Specify)				
۵.	1. Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	26b. TIME INJUI	RY WO	JRY AT RK? ES 2 NO	28d. DEŞCRIBE HOW	NJURY OCCURED			
ED BY	2 Accident Investigation 3 Suicide 6 Could not be	26a. PLACE OF INJURY building, etc. (Spec	' — Al home, larm, atr	eel, factory, office		261. LOCATION (Street City or Town, State)		Route Number,		
	4 Homicide detarmined						<u></u> : _			
COMPLET	(Check only	EIAN: To the best of my know to On the bests of examination						J.,		
3 E	29b. SIGNATURE AND TITLE OF CERTIFIES		The wind of the stigetters	in my opinion, o	29c. LICENSE NUN			(Month, Day, War)		
0	IN	~ MD			D331	65	> ()	78/94		
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	- 1.1	work (26.	Jan Lal	.) .!!	21074		
	31. DATE FILED (Month, Day, Year) NOV3 () 1994	32. AEGISTRAR'S SIGN	ATURE.			100	4 2 0	- 2.01		
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DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 5 should be detached for use as the burial-transit permit. Pages
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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29b. SIGNATURE AND TITLE OF CERTIFIE

31. OATE FILED (Month, Day, Year)

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First Middle Leat) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR Charles Harry Vaughan November 1994 24 1705 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) 159-05-2142 DAYS HOURS 1 X M 2 | F 90 Sept. 25, 1904 Pennsylvania 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Calvert Manor Nursing Home Rising Sun Cecil RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY Maryland Cecil E1kton 1 TES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 125 Overbrook Lane 21921 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Merried 2 X Merried 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced White 15. DECEOENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only higher H Triangle Publishing Co. College (1-4 or 5+) Elementery/Secondary (0-12) COMPL Accountant Accounting 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) Harry Vaughan Mary Fischer BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 5 Margaret A. Vaughan 125 Overbrook Lane - Elkton, MD 21921 20g. METHOD OF DISPOSITION
1AJ Burlel 2 Cremation 3 Removal from State 1 DATE 20 20c. LOCATION - City or Town, State 20b. PLACEAND DATE OF DISPOSITION (Name of New Cathedral Cemetery 1994 4 Donation 5 Other (Specify) Philadelphia, PA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE

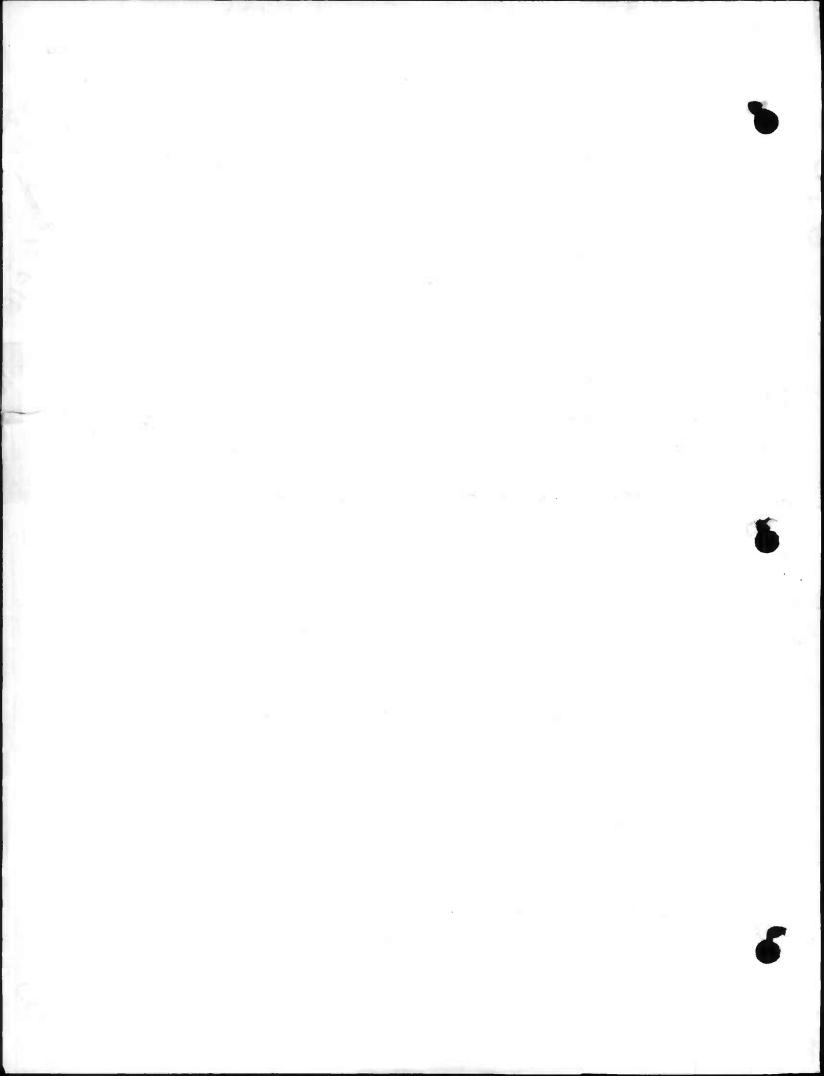
22. NAME AND ADDRESS OF FACILITY
HICKS Home for Funerals, P.A.

103 West Stockton Street
Fikton MD 21921-5521

23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest,
shock or heart failure. List only one cause on each life. Approximete shock, or heart feiture. List only one ceuse on each line Interval Between IMMEDIATE CAUSE (Finei **Onset and Death** Ca Bleddez diseese or condition resulting in deeth) CERTIFICATION Sequentially liet conditions, OUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL WERE AUTOPSY FINDINGS Dementia AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 TES 2 NO OF DEATH? 1 TES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\precedent \) NO \(\precedent 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 Other (Specify) 27. MANNER OF GEATH 28e. OATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Netural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 3 Sulcide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide

29e. CERTIFIER
(Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner se stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner se stated. 20c. LICENSE NUMBER
123322 29d. DATE SIGNED (Mogth, Day, Your) 25/94 Vachders 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S.S. Sachdev, M.D. - 118 North Street - Elkton, mD 21921 32. REGISTRAR'S SIGNATURE

JUNE DAY OF PROBLE



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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 rouns after death. Page 6 may be retained by the hospital or attending physicians.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frouts after death. Page 6 may be retained by the hospital or attending physician. TO THE SINKEAL DIRECTING they this cardificate has been sined by the attending physician and completely filled in by the funeral director case 5 should be described for use as the burisal-branei nermal Peaces 1.2	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: Il Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITA	MPORTANT: N

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last) MAR	Y ELIZABE			2. DATE OF DEATH MONTH DAY	YEAR 3. TIME OF DEATH
j	217-24-0241	□ MXX F 68	YRS.	FUNDER 1 YEAR FUNDER 24 HRS. HTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) MAY 31-26	
TOR	90. FACILITY NAME (If not institution, give stree ANNE ARUNDEL M RESIDENCE OF DECEDENT			ANNAPOLIS		NNE ARUNDEL
DIRECTOR	100. STATE 100. COUNTY MD ANNE AR	RUNDEL	10e. CITY, T			NSVI LIFTY 2 [XNX X
FUNERAL	1 Never Married 2 Married	TERBURY RI 2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	U.S. ARMED	101. ZIP CODE 2 1 0 3 2 13. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic 1 YES 2 NW Spec	NIC ORIGIN? (Specify Yes or No- an, Puerto Rican, etc.)	Black, White, etc.
COMPLETED BY	15. DECEDENT'S EDUCAT (Specify only highest grade co	TION mpleted)	16a. DECEDENT'S US	UAL OCCUPATION k done during most of working	16b. KIND OF BUSINESS/	AAFRO. AMERICAI
MPLE	12	College (1-4 or 5+)		T. MEADE ARM	Y EXCHANG	E
BE CO	17. FATHER'S NAME (First, Middle, Lost) HARRY EDWAR	9)				
5	JUANA VEGA		196. MAILING AD	ODRESS (Street and Number or Rural	Route Number, City or Town, State,	Zip Code)
	20e. METNOD OF DISPOSITION 1	20b. cem	PLACE AND DATE OF I	ANS DEC. 2	-94 CROWN	- City or Town, State VS VT I.T.E. MD
	21. SIGNATURE OF FUNERAL SERVICE LICEN CHARLES E. H.)	DXX	22/NAME AND ADDRESS OF F		S,MD. 21401
	23. PART I. Enter the disease, or consher shock, or heart feliure. Lie immediate CAUSE (Final disease or condition resulting in death)	nplications that coused at only one cause on early one cause on early one as a	reliae	enter the friede of dying, e	ch as cardiac or respiratory	Approximata interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		CONSEQUENCE OF	o Mel	/	154RS
PHYSICIAN: MEDICAL CE	Mydenia;	contributed of death is	for resulting in the first of t	Minderfritti Lause giver la	1 Part I. 24a. WAS AN AUTOP PERFORMED? 1 1 YES 2 1 NO	AWAILABLE PRIOR TO
BY PHYSICIA		10SPITAL: inpetient 2 in EP/Outp 28a. DATE OF INJUSTY (Morm, Day, Year)	28b. TIME C	WORK?	e ☐ Other (Specify) 28d. DESCRIBE HOW BIJURY	
- 1	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF BUJURY building, etc. (Spec	— At name, term, attra	es, ractory, office	28f. LOCATION (Street and Alun City or Town, State)	scient of Hurar results Numbec
TO BE COMPLETED	2 MEDICAL/EXAMINER 295. SIGNATURE AND THE GO CERTIFER 36. NAME AND ADDRESS OF PERSON WHO	On the back of examination	n end/or Investigation,	DIH	to time, date and place, and due to	to the cause(e) and menner ea stated. DATE SIGNED (Month, Day, Next) 12-1-94
	Same. 13	300 Kych	ue Hu	My Arrald/	1d 21010	

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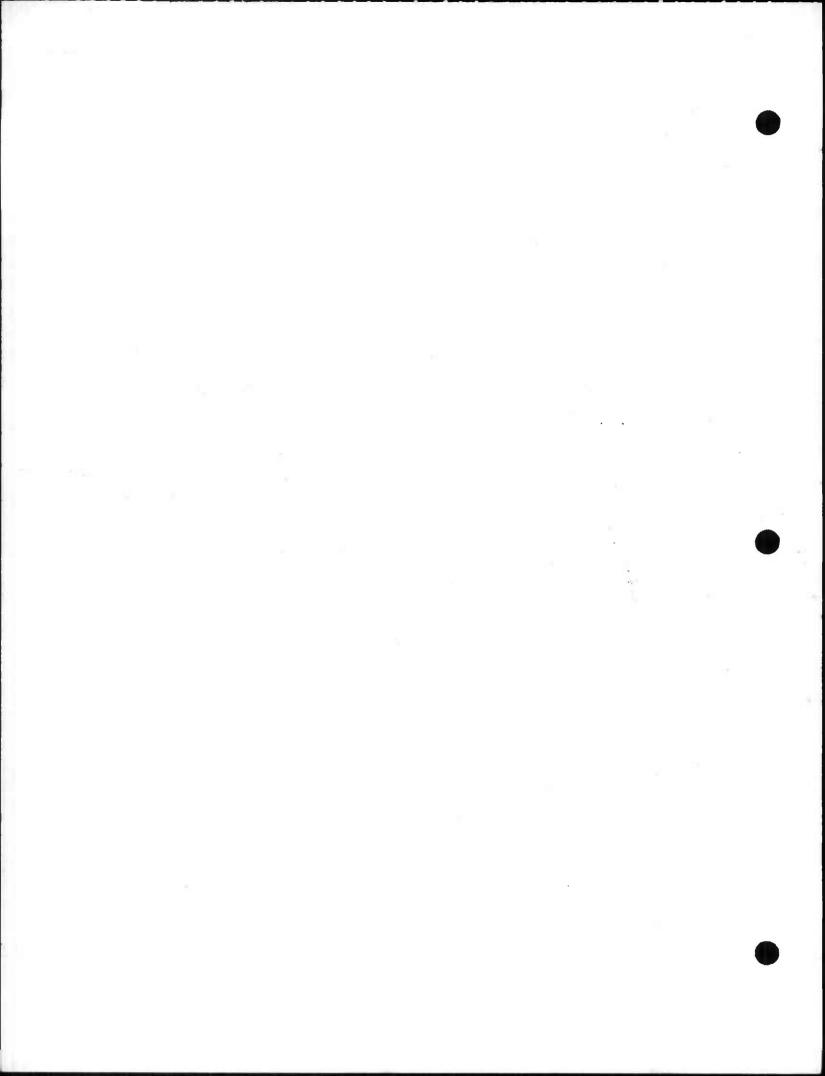
THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2x hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

	REGIOTIAN	·	<u></u>		CALL	_ 01	DEA			REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Lest) ANTHONY	V. VER	Sis						2. DATE (OF DEATH DA		YEAR 3	TIME OF DEATH
- 9	4. SOCIAL SECURITY NUMBER	5. SEX 6	. AGE (In yrs. last	birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.		OF BIRTH		8. BIRTNPL	ACE (State or Foreign
ı	578-26-6949	1 1 1 1 2 □ F	67	YRS.	MONTHS	DAYS	HOURS	MIN.		Day, Year)	26	Wash	ington D.C.
	9e. FACILITY NAME (If not institution, give str	reet and number)			9b. CITY	, TOWN C	OR LOCATION	ON OF DE		, -		NTY OF DEA	
HC	WASHINGTON A	FOVENTIS	T Hos	P.	TA	-Ko	ma	PK			m.	7010	nomercy
5	RESIDENCE OF DECEDENT								•		/	7,0	
DIRECTOR	(2 1.		10c. CIT	r, TOWN								0d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	. 9.			136	w,e							YES 2 NO
FUNERAL		D				101	. ZIP CODE				10g. CITI	ZEN OF WH	AT COUNTRY?
N	8014 Quill 7.	12. WAS DECEDENT I	DIED IN II C ADI	450	Lan		20	1 /	>				tates
	₩X Never Married 2 Married	FORCES? 1X	YES 2 N			If yes, sp	ecify Cuba	n, Maxica	n, Puario R	(Specify Yes lcan, etc.)	or No-	14. RACE - Black, 1	- American Indian, White, etc.
BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR				1 YES	2 🖺 NO	Specify	N. N	0	Ì	Specify:	White
COMPLETED	15, DECEDENT'S EDUC (Specify only highest grade of	ATION	16e, DE6	CEDENT'S	USUAL O	CCUPATIO	ON		16b.	KIND OF BUS	INESS/IND	USTRY	
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MPI	12		Iro	n Wo	rker				Ei	rectio	n w	rougn	t Iron
8	17. FATNER'S NAME (First, Middle, Last)									liddle, Maiden	,		
BE	Nicholas Anthony	Versis					Ca	ther	cine	Chamou	ıris		
0	19e. INFORMANT'S NAME (Type/Print)		1							er, City or Town			20722
	Renate M. Lazear							Driv	re B	owie M	laryl	and	20720
	20a. METHOD OF DISPOSITION 13 Burial 2 Cremation 3 Remo	wal from State	20b. PLACE A						DATE			City or Town	
	4 Donation 8 Other (Specify)	FNSE	Maryi	and									m, Md.
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	1)0000	Vans) -						d. Bow			715
	23. PART I. Enter the diseasee, or conshock, or heart failure. L	omplications that p list only one cause	faused the de-	eth. Do n	Ot enter	the mo	de of dyl	ng, suc	h es cerd	lec or respi	ratory srr	est,	Approximata Intervei Between
	IMMEDIATE CAUSE (Final	11		7		4	` n						Onset and Dasth
-	disease or condition resulting in death)	. Vicey	ocasé	Ha	6 '	Yeu	levi	2					
		DUE TO/O	R AS A CONSEC	UENCE OF).		0	-					
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¥	if sny, leeding to immediate cause. Enter UNDERLYING					0							
Ĕ	CAUSE (Diseese or injury that initieted events	DUE TO (O	R AS A CONSEO	UENCE OF):								
ᇤᅵ	resulting in deeth) LAST			_									
	PART II. Other significent conditions	contributing to de	eeth but not re	eulting i	n the un	derlying	2 001180 0	duen in	Part i	24a. WAS AN	ALITOROV	T 0.45 H	ERE AUTOPSY FINDINGS
EDICAL				ounting .		.comy	g codeo s	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	OIL I.	PERFOR	MED?	. A	WAILABLE PRIOR TO OMPLETION OF CAUSE
									—	1 TYES 2	NO	0	F DEATH?
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A	25. WAS CASE REFERRED TO MEDICAL	IBOTE TO CAO.		E OF DEAT) UNC	ERTAIN	4 L				
PHYSICIAN:	EXAMINER?	HOSPITAL:			OTHER	₹:		aldanaa	8 🗆 Other	/Cai4-i			
Ĭ	27. MANNER OF DEATN	28e. DATE OF IN	JURY	28b. TIMI	OF	26c. INJ	URY AT	siderica		CRIBE HOW IN	JURY OCC	URED	
	1 Natural 5 Pending	(Month, Day,	Year)	INJ	M	1 🗌 1	RK? (ES 2 [NO					
BY	2 Accident Investigation 3 Suicide 6 Could not be	28a. PLACE OF II	NJURY — At hor	ne, ferm, a	traat, fact	ory, office			28f. LOCA	TION (Street a	nd Number	or Rural Rou	ite Number,
COMPLETED	4 Homicide determined	building, ato	с. (эрвспу)						City o	r Town, State)			
٦ ا	29a. CERTIFIER (Check only	CIAN: To the best of my	knowledge, des	th occurre	d at the I	lme, date	and place.	and due	to the caus	e(a) and man	ner ea stat	ed.	
<u> </u>	one) 2 MEDICAL EXAMINER												nd manner as stated.
Ŭ U	29b. SIGNATURE AND TITLE OF CHATTERIN						29c. LICE						fonth, Day, Year)
m ∥	4000	05					D 28	8883			D/1	1981	96
임	30. NAME AND ADDRESS OF PERE SHEWILL	LETED CAUSE	OF DEATH (ITEM	27) (Туре,	Print)						- (, 0/	: T
ł	1706 Nev	v Hampshin	re Ave.	Wasl	n. D	.C.	2000	9					
	31. DATE DECO 2 1994	32. REGISTRAN	S SIGNATURED	ndo									
	QLOU 2 1334	- Ena jour	140012-11	- 1-									



OX 68760 BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

THE HOSPITAL OR ATTENDING PHYSICIAN: The two requires that the death certificate be sentuted within minute after death. Page 6 may be retained by the hospital or attending physician	TO THE FUNERAL DIRECTOR: Ame this certificate has been signed by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-tra	loval.	/ IMPORTANT; If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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CERTIFICATION

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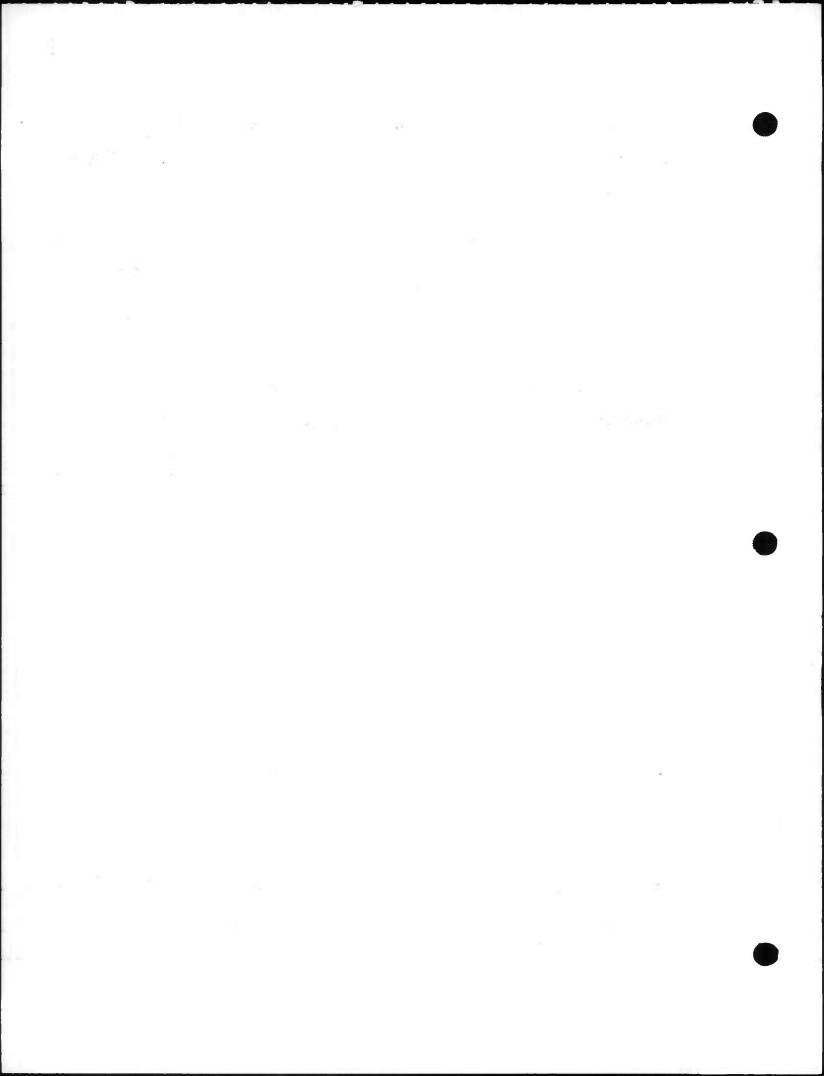
31. DATE FILED (Month)

NOV 2 9

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME Triest, Middle, Last, 1920 hours OF DEATH Vieira Regina 1994 1930 how 10 in Det 30, Raposo 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. July 27,1916 Fall River MA 014-07-6861 78 1 M 2 XF 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Prince George's Hospital Cheverly Prince George's RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 NO Maryland Prince George's Clinton 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6107 Arbroath Drive 20735 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 WHO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: Specify: 3 Widowed 4 Divorced Caucasian 15. DECEDENT'S EDUCATION 16a, DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g Elementary/Secondary (0-12) 8th Seamstress Clothing 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Manuel deS. Raposo Delfina deSousa 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Ford 3566 Neale Ct. Waldorf, Maryland 20602 20e. METHOD OF DISPOSITION

XXBurlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE cemetery, crematory or other place) ☐ Donation 5 ☐ Other (Specify) Cemetery Fall River MA
22. NAME AND ADDRESS OF FACILITY LEE FUNETAL HOME, Notre Dame Cemeter 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 6633 Old Alexandria Ferry Rd Clinton, Md 2d23 23. PART I. Enter the diseases, or complicatione that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Approximate ehock, or heart fellure. List only one ceuse on eech line. IMMEDIATE CAUSE (Final Onset and Death disease or condition tenoselestre Cardio pascular disea (seal) resulting in death) DUE TO UPR AS A CONSEQUENCE OF: Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 345. WERE AUTOPSY FINDINGS COMPLETION OF CAUSE 1 YER 2 GHO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26, PLACE OF DEATH (Check only one) EXAMINEDY 1 MES 2 NO HOSPITAL: fleet 2 ER/Outpetient 3 C DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF-BEATH 28s. DATE OF INJURY (Monty, Day Worl) 28c. INJURY AT WORK? 38d. DESCRIBE HOW INJURY OCCURED 1 Neturel M T YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Flural Route Number City or Rown, State) 3 Suicide 6 Could not be determined 29s. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dwelft occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the on and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and me 29b. SIGNATURE AND TITLE OF CERT LICENSE NUMBER



BALTIMORE, MARYLAND 21215-0020	be executed within four after than Place 6 may be retained by the hospital or attending physicia
MARY	e retained by
IMORE,	Tage 6 may by
BALT	after death.
	SUNDE
X 68760,	executed within
2	8

BALTIMORE, MARYLAND 21215-0020	down while on the first of may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the function page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should bit the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remove.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jours after four than the base to may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removed	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

AEMENT

NOV 2 9 1994

30. NAME AND ADDRESS OF PERSON W/O COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

3

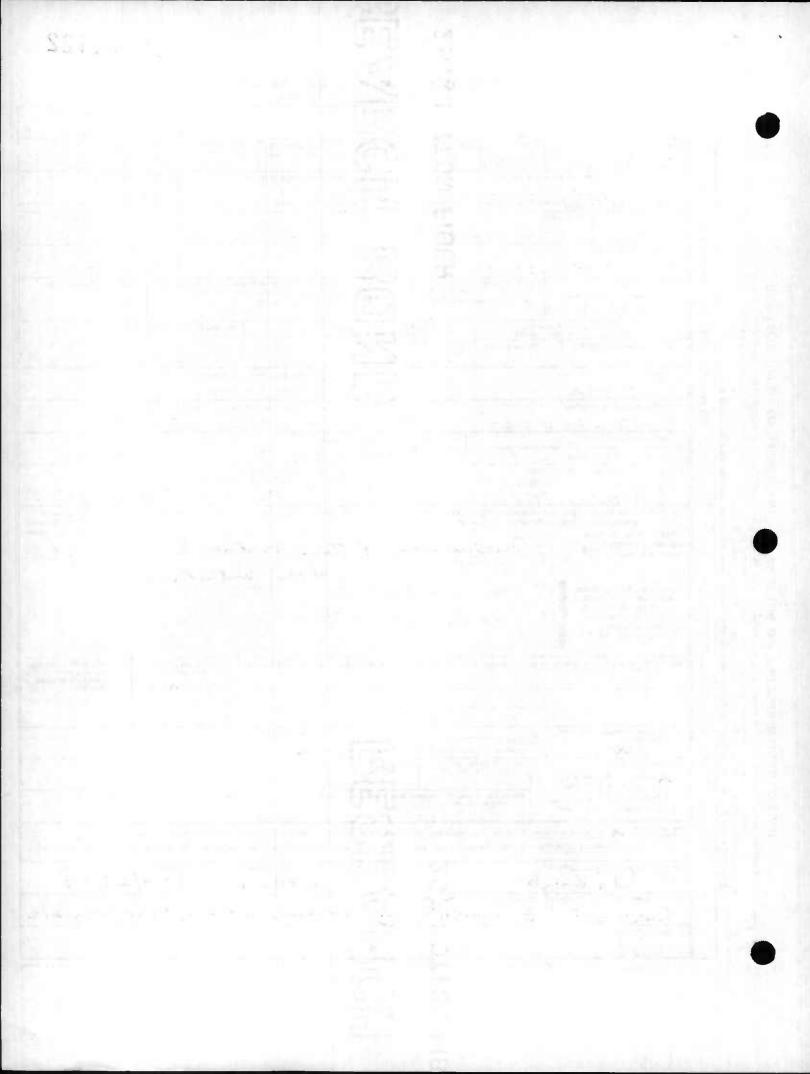
KNISH?

32. REGISTRAR'S SIGNATURE Davideor Reverly

		CE					OF DEATH			3. TIME OF DEATH						
OLGA VAN S	PLINTER					Nov	0		YEAR	11:30 A						
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. lest		DER 1 YEAR	IF UNDER 24 HRS.	7. DATE C	OF BIRTH		8. BIRTH	IPLACE (State or Foreign						
138-01-3429	1 M 2 F	73	YRS. MONTH	DAYS	HOURS MIN.		e 29,	1921	New	Jersev						
9a. FACILITY NAME (If not institution, give st	reet and number)		9b. CI	TY, TOWN	OR LOCATION OF D			_	INTY OF D							
12060-H Little Patuxent Parkway Columbia Howard																
100. STATE 10b. COUNTY Maryland		ward	10c. CITY, TOWN	umbia						10d, INSIDE CITY LIMITS? 1 YES 2 X NO						
10e. STREET AND NUMBER		/wara	001		I. ZIP CODE			10g. CIT	IZEN OF V	VHAT COUNTRY?						
12060-H Little P	atuxent P	Parkway			21044			IIr	nited	States						
11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. ARM		3. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN	? (Specify Ye			E — American Indian, t, Whita, atc.						
1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 [IF YES, GIVE WA	YES 2 NO			ecify Cuban, Mexica 2 A NO Specif		ican, atc.)		Speci Whi	My:						
15. DECEDENT'S EDUC (Specify only highest grade	CATION	16a. DEC	EDENT'S USUAL	OCCUPATION	ON	16b.	KIND OF BU	SINESS/IN	DUSTRY							
Elementary/Secondary (0-12)	College (1-4 or 5+)	Ma I	e kind of work dor Do NOT use retired	ne auring mo f.)	ist of working											
12		Hot	memaker				01	vn Ho	ome							
17. FATHER'S NAME (First, Middle, Last)				4	16. MOTHER'S NA	ME (First, M	liddle, Maiden	Surname)								
Samuel Jorbel					Mary H	Roman	ac									
19e. INFORMANT'S NAME (Type/Print)		196.	MAILING ADDRE	SS (Street a	and Number or Rural	Route Numb	er, City or Tow	n, State, Zi	p Code)							
Russell R. Van S	plinter		7732 Tw	in Oa	aks Way I	Laure	1 Mar	land	1 207	23						
20a. METHOD OF DISPOSITION SCENE 1 2 □ Cremation 3 □ Remo	oval from State		NO DATE OF DISP			DATE		CATION —	City or To	wn, State						
Laurel Grove Cemetery 11-29 Totawa, New Jersey																
21. BIOHATURE OF FUNERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Harry H Witzke Funeral Home Inc																
Harry H Witzke Funeral Home Inc 4112 Old Columbia Pike Ellicott City21043																
23. PART I. Enter the diseases, or c	omplications that	Caused the dea								Approximata						
shock, or heart failure. I	List only one caus	on each line.								Interval Between Onset and Deat						
IMMEDIATE CAUSE (Final disease or condition)									13-1							
DUE TO (OR AS A CONSEQUENCE OF):																
disease or condition resulting in death) Due to (or as a consequence of): Live wetastages																
Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE OF):															
CAUSE (Disease or Injury that initiated events	CDUE TO (OR AS A CONSEQUENCE OF):															
resulting in death) LAST																
resulting in death) LAST																
						_		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY AMAILABLE PRIO								
	s contributing to d	death but not re-	aulting in the	underlyln	g cause given in	Part I.	24s. WAS AN PERFO	AUTOPSY	140	MAILABLE PRIOR TO						
	s contributing to c	death but not re	aulting in the	underlyln	g cause given in	Part I.	24s. WAS AN PERFO	RMED?								
	s contributing to c	death but not re	aulting in the	underlyin	g cause given in	Part I.	PERFO	RMED?		MAILABLE PRIOR TO COMPLETION OF CAUSE						
	s contributing to c	death but not re	aulting in the	underlyln	g cause given in	Part I.	PERFO	RMED?	240	MM/LABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?						
PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL		death but not re		26. PI	g cause given in	_	PERFO	RMED?	240	MM/LABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?						
PART II. Other significant conditions	HOSPITAL:		ОТН	26. PI		eck only one	PERFO	RMED?		MM/LABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?						
PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	ER/Outpatient 3 (DOA OTH 4 DOA 28b. TIME OF INJURY	26. PI ER: lursing Hom 28c. INJ	LACE OF DEATH (Ch.	eck only one	PERFO	MED?		MM/LABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?						
PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation	HOSPITAL: 1 Inpetient 2 Inpetient 2 (Month, Day	ER/Outpatient 3 [NJURY , Year)	DOA 4 OTH	26. Pi ER: lursing Hom 28c. INJ W0	LACE OF DEATH (Ch. 10 5 Residence IURY AT 19K7 YES 2 NO	6 Other	PERFOI YES : (Specify) CRIBE HOW	NJURY OC	COURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO						
PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	HOSPITAL: 1 Inpetient 2 28e. DATE OF I	ER/Outpatient 3 (DOA 4 OTH	26. Pi ER: lursing Hom 28c. INJ W0	LACE OF DEATH (Ch. 10 5 Residence IURY AT 19K7 YES 2 NO	6 Other	PERFOI YES : (Specify) CRIBE HOW	NJURY OC	COURED	MM/LABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?						
PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: 1 Inpetient 2 25e. DATE OF I (Month, De) 25e. PLACE OF building, e	ER/Outpatient 3 (NJURY y, Year) INJURY — At homotic. (Specify)	DOA OTH 4 N 26b. TIME OF INJURY M we, farm, street, fi	28. PI ER: lursing Hom 28c. IN, WC 1 1	LACE OF DEATH (Chine 5 Residence IURY AT RRK? YES 2 NO	6 Other 28d. DESd. City o	PERFOI 1 YES : (Specify) CRIBE HOW I	NJURY OC	CCURED or or Rural F	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO						
PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: 1 Inpatient 2 28e. DATE OF I (Month, De) 28e. PLACE OF building, e	ER/Outpatient 3 C NJURY y, 'bea') INJURY — At hom tc. (Specify) my knowledge, deat	DOA 4 N 4 N 28b. TIME OF INJURY M e, farm, street, fi	26. PI ER: lursing Hom 28c. INJ 1	LACE OF DEATH (Ch	eck only one 6 Other 28d. DE\$d. 28f. LOCA City o	PERFOI 1 YES : (Specify) (Specify) CRIBE HOW TION (Street Frown, State,	NJURY OC	CORED or or Rural F	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO						
PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	HOSPITAL: 1 Inpetient 2 Inpetient 2 See. DATE OF Infection (Month, De) 28e. PLACE OF building, e	ER/Outpatient 3 C NJURY y, 'bea') INJURY — At hom tc. (Specify) my knowledge, deat	DOA 4 N 4 N 28b. TIME OF INJURY M e, farm, street, fi	26. PI ER: lursing Hom 28c. INJ 1	LACE OF DEATH (Ch	8 Other 28d. DESt City o	PERFOI 1 YES : (Specify) (Specify) CRIBE HOW TION (Street Frown, State,	NJURY OC	or or Rural R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO						

revael hedicine,

HCGH



			FOR 1 - STATE REGISTRAR	STATE OF MARY	LAND / DEPA CERTII	RTMENT OF I	HEALTH AND I	MENTAL HYGIEN				
			1. DECEDENT'S HAME (First, Middle, Last)					2. DATE OF DEATH 3. TIME OF DEATH				
	ing physician. the burial-transit permit. Pages 1, 2, 3 should		John Thomas VAUGHN, Jr. 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR					7101 29 1994 15:30				
			212-14-7300 9a. FACILITY NAME (If not institution, gi	15€ M 2 🗆 F 7	7 1 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) March 21,	1923	BIRTHPLACE (State or Foreign Country) Maryland		
		TOR							9c. COUNTY OF DEATH Washington			
		DIRECTOR	10a. STATE 10b. COU		ngton Hagersto					10d. INSIDE CITY LIMITS? 1 🔀 YES 2 🗌 NO		
	berm	3AL	10e. STREET AND HUMBER			101. ZIP CODE			10g. CITIZEI	H OF WHAT COUNTRY?		
ian.	-transi	FUNERAL	28 South Locust	Street 12. WAS DECEDENT EVER	IN II S ADMED	21740			NIC ORIGIN? (Specify Yea or Ho = 14, RAG			
21215-0020 or attending physician.	the burial	ВҰ	1 Hever Married 2 Married 3 Widowed 4 Divorced	FORCES? 1X YE	FORCES? 1 YES 2 HO If yea, specify Cuban, Me IF YES, GIVE WAR OR OATES 1 YES 2 14 NO So			n, Puarto Rican, etc.)	. RACE — Amarican Indian, Black, White, etc. Specify: White			
1219 r atten	use as	ETED.	15. DECEDENT'S E (Specify only highest gi	EDUCATION rade completed)	(Give kind or	S USUAL OCCUPATI		16b, KIHD OF BU	SINESS/INDUS	TRY		
100	be detached for use at once.	PLE	Elemantary/Secondary (0-12)	College (1-4 or 5+)	main	tenance		city	light			
MARYLAND are retained by the hospital	once.	COMPL	17. FATHER'S HAME (First, Middle, Last)					ME (First, Middle, Maiden	Surname)			
RYI ed by		BE (John Thomas Vau	ghn, Sr.				iana M. We				
- 8	be notified	2	Betty Vaughn		28 S	. Locust	St., Hag	Goute Number, City or Townserstown,				
ORE 6 may	must I		20a. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 R 4 Donation 8 Other (Specify)	lamoval from State	ob.PLACE AND DATE emetery, cremetory of Rose Hil	of Disposition (No other place)	eme of rv 12-2			or Town, State Wn, Maryland		
TIM.	z4 nours after death. Pag filled in by the funeral dis tion, or removal. The medical examiner	ļ	21. SIGNATURE OF FUNERAL SERVICE		~		NO ADDRESS OF FAI		Beroco	an, naryland		
BALTIM er death. Page			Scott	Millen	rell				gersto	wn, Md. 21740		
24 hours			23. PART i. Enter the diseases, ehock, or heart failu iMMEDIATE CAUSE (Finel disease or condition resulting in death)	ra. List only ona cause on	aach lina,					Approximate interval Between Onset and Death		
68760.	5 - 6		disease or condition reaulting in death) a. Respiration Facilities DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF):									
Secure Secure	matic o	RTIFICATION	Sequentielly list conditions, if any, leading to immediate b. A Security Sequential Seq									
BOX	prior tra	CAI	cause. Enter UNDERLYING CAUSE (Disease or Injury C. Change of the Line Pulmery Directory)									
0 = 5	ttal Hygiene	RTF	thet initiated evente DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST									
S P	Mental Injury, o	빙	DADT II Other elemiticant condit	tions contributing to death	h							
~ = 3	- g	CAL	PART II. Other algnificent condit				g ceuse given in	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE		
RECOR	of Health an	MEDIC/	ming There					1 YES 2	≀	OF OEATH?		
CC 20 3	Dept. of F	N.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
T Per	State D	YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 - NO	HOSPITAL:		OTHER:						
OF V	the the	PHYS	27. MAHHER OF DEATH	1 Mpatient 2 ER/Ou 28e. DATE OF IHJURY	Y 28b. TI	ME OF 28c. IHJ	IURY AT	8 Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCUR	ED		
O N		ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year))		YES 2 NO					
DIVISION OF VITOR OF ALL OR ATTENDING PHYSICIAN:	after d		3 Suicide 8 Could not be building, atc. (Specify) 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify)							CATION (Street and Number or Rural Route Number, ty or Town, State)		
DIV	2 hours	COMPLET		YSICIAN: To the best of my kno								
HOSPITAL	Within ANT:	S	2 MEDICAL EXAM	IINER: On the beels of examinet	ion and/or investigati	ion, in my opinion, c			id due to the ce	iuse(a) and manner as stated.		
TE	be filed within 72 h	BE	296. SIGNATURE AND TITLE OF CERTIF	PLOT NO			D (80			GNED (Month, Day, Year)		
2 2	2 8 Z	5	30. NAME AND ADDRESS OF PERSON					ERSTOWN				
				32. REGISTRAR'S SIG	NATURE			TX 7. (600 V	~n)	L () M 0		
			31. DATE FILED (Month, Day, Year) DEC 0 2 1994	Jani Benden K	mark							

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pa be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the be filed within 72 hours after death with the State Dept. of Health and M	IMPORTANT: It Item 28 Is marked, or Item 23 shows any inj

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /		OF HEALTH AND	MENTAL HYGIEI						
	1. DECEDENT'S NAME (First, Middle, Last)	Δ),1:	illiam	c	2. DATE OF DEATH	DAY C Y	3. TIME OF DEATH				
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. la:			7. DATE OF BIRTH	3 44	6. BIRTHPLACE (State or Foreign				
	216-16-3737	N 2 □ F 75	YRS. MONTHS	DAYS HOURS MIN.	(Month, Day, Year)	1919	Country) HARVAND				
JR.	98. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH Falls for General Hospital Falls for Harring										
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY										
- 1	MARY/AND F	TARFORD		Edgewo	400		LIMITS?				
FUNERAL	19/7 E/01	SE LAN-	e .	101. ZIP CODE 2 104	40	10g. CITIZE	N OF WHAT COUNTRY?				
NO.	11. MARITAL STATUS	2. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2		MAS DECENDENT OF HISPA f yea, specify Cuban, Maxic	NIC ORIGIN? (Specify Y	18 or No- 14	RACE — American Indian, Black, White, atc.				
B	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES		YES 2 NO Specific		specify: B/ACK					
TED	15. DECEDENT'S EDUCAT (Specify only highest grade cor	mpleted) (G	ECEDENT'S USUAL OF Give kind of work done of D. Do NOT use retired.)	CCUPATION during most of working	16b. KIND OF BI	JSINESS/INDUS					
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	meta	ker	PR	IVATE	Estate				
_	17. FATHER'S NAME (First, Middle, Last) Seymour	Will	112m c	16. MOTHER'S NA	AME (First, Middle, Meide	n Surname)					
O BE	19a. INFORMANT'S NAME (Type/Print)	19	b. MAILINO ADDRESS	(Street and Number or Rural	Route Number, City or To	wn, State, Zip Co	ude)				
-	Thomas Will 200. METHOD OF DISPOSITION	LIAMS IR.	1917	Eloise 4	LANC F	tARFO1					
	1 Burial 2 Cremation 3 Remova	of from State cometery, cre	AND DATE OF DISPOS emetory or other place)	and Cery	12-7-84	Dela Dela	UP MARKAMIN				
	21. SIGNATURE OF FUNERAL BERVICE LICEN	SEE D. ASA	22.	NAME AND ADDRESS OF FA	THE FUNCEA	2 Sepu	ice 21084				
_	Durch	VI elle		2006014 Fe	desal HILL	Reno -	IMPREHSVILLE MA				
		mplications that caused the de it only one cause on each line					Interval Between				
	immediate Cause (Finel disease or condition resulting in death) Puptured abdominal acts animal consequence of: Onset and Death Skies										
_		DUE NO (DR AS A CONSE	OUENCE OF):			1					
5	Sequentielly liet conditione, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
RIFICATION											
SER											
AL	PART II. Other significent conditions of	contributing to death but not i	reculting in the un	deriying ceuee given in	Pert i. 24a. WAS AI	N AUTOPSY	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO				
HISICIAN: MEDIC					1 YES	2 NO	COMPLETION OF CAUSE OF DEATH?				
2	DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF DEA	TH YES 1	NO DE UNCERTAI	N D		1 TYES 2 NO				
2		IOSPITAL:	OTHER								
2	1 YES 2 NO	Inputient 2 ER/Outputient 3	28b. TIME OF	28c, INJURY AT	6 Other (Specify) 28d. DESCRIBE HOW	IN HUMY OCCUM					
-	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year) INJUS		WORK?	284. DESCRIBE HOW	20					
150 8	3 Suicide 6 Could not be datarmined	28s. PLACE OF INJURY — At he building, atc. (Specify)	ome, farm, street, facto	ory, office	28f. LOCATION (Street City or Town, State	and Number or Rural Route Number,					
	29a. CERTIFIER (Check only	29s. CERTIFIER CERTIFICAL PLANCICIAN, To the boundary of the certification of the certificati									
2		On the basis of exemination and/or					suse(s) and manner sa stated.				
	29b. SIGNATURE AND TITLE OF CHRTIFIER	1 Mis		29c. LICENSE NUI	MBER 2	29d. DATE SIGNED (Month, Day, Year) > 12 - 3 - 9 4					
2	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEATH (ITE	M 27) (Type, Print)	2) - 1 0							
	S(O)T S, H 31. DATE FILED (Month, Day, Year)		N. HIC	Sun to 10	1 13el A	ir o	1014				
	DEC 0 5 1994	32 REGISTRAR'S SIGNATURE	dall								

		FOR 1 - STATE REGISTRAR	STATE OF N	MARYLAN	ID / DEPAR	RTMENT	OF H	IEALTH DEA	AND I	MENTA	L HYGIEN				
		1. OECEGENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH								YEAR	3. TIME OF OEATH				
		JERRALD		WASHINGTON						94	2 · 20 A M				
	1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In y	rs. last birthday)	IF UNDER	DAYS	IF UNDE	R 24 HRS.		OF BIRTH		8. BIRTHP Country,	LACE (State or Foreign	
pinous		219-86-0286 9e. FACILITY NAME (If not institution, g	1 M 2 F	20	YRS.	OL OUT	TONO.				T. 8,	V		YLAND	
2, 3 shc	стов	PHYSICIANS MEMORIAL HOSPITAL LAPLATA CHARLES													
es ,	RECI	RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION									T	10d. INSIDE CITY			
permit. Pages	□							NANJEMOY					1		
. isi	FUNERAL	100. STREET AND NUMBER ROUTE #6 BOX 99)A				101	206						TATES	
020 physician. burial-transit	5	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.	S. ARMED	13.	WAS DEC	ENCENT	OF HISPAN	IIC ORIGII	N? (Specify Ye		14. RACE	- American Indian,	
	B	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W 1992-	WITH OR CATES	s NO			2XXNO			Ricen, atc.)		Specify	BLACK	
	윤	15. DECEDENT'S (Specify only highest g	16	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working				ina	16b. KIND OF BUSINESS/INDUSTRY			USTRY			
b 27 spital o	IPLET	Elementary/Secondary (0-12) 12TH GRADE	College (1-4 or 5 d	College (1-4 or 5+)		ille. Do NOT use retired.) ENGINEER			GOVERNMENT (U.		(U.S	. NAVY)			
AND the hospil detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)			-			16. MOT	HER'S NA	AME (First, Middle, Malden Surneme)					
# E E	BE (JERROLD DOUGLAS	WASHINGTO	N				-		LA MAE MONTGOMERY WASHINGT				WASHINGTON	
retained 5 should notified	6	19e. INFORMANT'S NAME (Type/Print)									ber, City or Tov				
		BLANCHE L. WASH	INGTON	001.01		_			NAN.	-	Y, MAR			662	
7 9 8 8		20c. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Line Place) ARYLAND VETERANS CEMETERY 12/9 94 CHELTENHAM, MARYLAND													
Page al direc		21. SIGHLEGRE OF ELIMERAL SERVICE LICENSEE THORNTON FUNERAL HOME, P.A.													
death death e fune		LIDIA C. THORNTON JOHNSON MO0583 INDIAN HEAD, MARYLAND 20640													
ted within 24 hours after completely filled in by the ial, cremation, or removal event, the medical		23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) But to (or as a consequence or):													
th certificate be executed ending physician and correct lygiene prior to burial, or other traumatic ex	CERTIFICATION	Sequentially list conditions, if any, is ading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated svents resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d													
that the the that and M	EDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.							PERFORMED? AM		WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
v requires that been signed b	Σ													YES 2 NO	
law law Dept. 23	AN:	DID TOBACCO USE COI				_		UNC	CERTAIN	۱ 🗆					
a se the	SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		PLACE OF DEA	OTHER	1 :								
SICIAN: The Certificate the State	РНҮЅ	YES 2 NO 27. MANNER OF OEATH	1 Inpatient 2X	INJURY	nt 3 🗆 DOA	_	28c. INJ		esidence		1.7	IN JURY OCC	IDED		
NG PHYS fler this c sath with marked,		1 Natural 5 Pending	(Month, Di	ay, Year)		J M	WO	MORK?			/	ct shot			
L OR ATTENDING PHYSICIAN: DIRECTOR: After this certifical hours after death with the St item 28 is marked, or it	D BY	2 Accident Investigation 3 Suicide 8 Could not	28e. PLACE O		At home, farm,	atreet, fect	ory, office	,			4	- ,		onic Lodge	
ATTER ECTOR S after	E	4 Homicide determined			arking	107	1			Kins	or lown, State,	R+30	mas anib	onic lodge	
2 2 N =	COMPLETED		IYSICIAN: To the best of IINER: On the bests of si							to the Cou	use(s) end me	nner es state	d.	end menner ee stated,	
TO THE HOSPIT TO THE FUNERA De filed within 7		296. SIGNATURE AND TITLE OF CERTI		, ,				29c. LICI	ENSE NUN	IBER		29d. DATE	SIGNED (Month, Day, Year)	
E E E E	TO BE	Denn	U1	uto,				0.	C.M	. F	Ξ	▶ DI	EC.4	.1994	
	É	30. NAME AND ADDRESS OF PERSON	WHA COMPLETED CAUS	SE OF DEATH	(ITEM 27) (Type 1 Pen	n St	tree							21201	
		31. DATE FILED (Month, Day, Year) DEC 0 6 19	94 Julia a	R'S SIGNATU	Revell										

retained by the hospital or attending physician. Раде 6 тау be requires that the death certificate be executed within

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL (
TO THE FUNERAL D
BE filed within 72 h
IMPORTANT: If It

31. DATE FILED (Month, Day, Year)

DEC 0 6 1994

Pages 1, 2, 3 should permit. funeral director, page 5 should be detached for use as the burial-transit once 듉 notified pe must the medical examiner the attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or removal. event. traumatic other 6 has been signed by t Dept. of Health and shows any HOSPITAL OR ATTENDING PHYSICIAN: The law 23 this certificate h 0 marked. After to DIRECTOR: , hours after 28

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENF CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Marcellous A. Washington YEAR MARCELLUS WASHINGTON Α. 7. DATE OF BIRTH 0. BIRTHPLACE (State o 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 12/10/ 54 1X X M 2 □ F 39 578-72-3782 Washington 9a, FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 5307 Deal Drive Prince Georges Oxon Hill 10b. COUNTY 10c, CITY, TOWH OR LOCATION 10d. INSIDE CITY Maryland Prince George's Oxon Hill XXYES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 905 Marcy Avenue, Apt. 20745 United States 11. MARITAL STATUS
1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE - American Indian, Black, White, atc. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cubsn, Maxican, Puarto Rican, atc.)

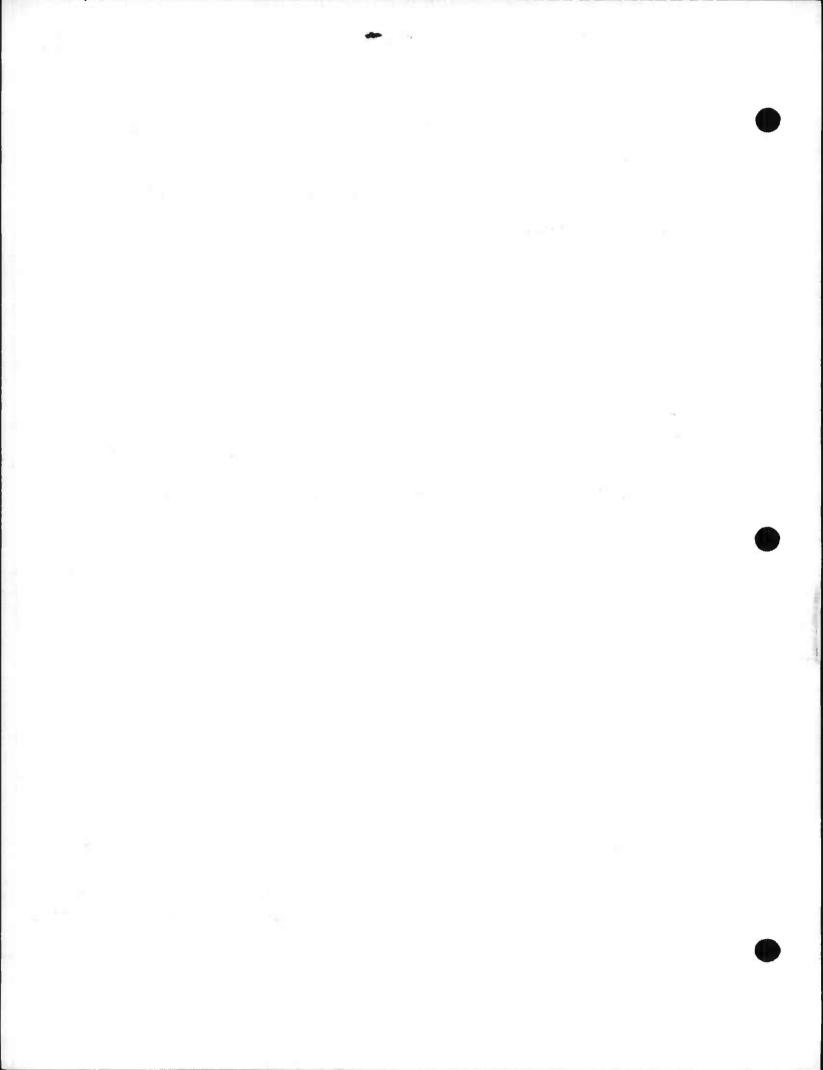
1 YES 2 NO Specify: BY Spocky: Black 3 Widowed 4 Divorced 60 tea. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only ETI Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL Skilled Laborer 1 7 + b 17. FATHER'S NAME (First, Middle, Last) Construction 18. MOTHER'S NAME (First, Middle, Maiden Surname) Baker A. Washington Anna C. Briscoe BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 2 Phyllis D. Washington 819 Marcy Ave. Apt. T.-4 Oxon Hill MD 20745 20c. LOCATION — City or Town, State 29s. METHOD OF DISPOSITION
t □ Burlel 2 ⑦ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 12/7/94, Alex. Virginia Metropolitan Crematory 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Adams Funeral Home, PA m. Aquasco Road, Aquasco, MD. 20608 Enter the displaces, or complications that caused the death. Do not antar the mode of dyling, such as cardiac or respiratory errest, shock, or hear fallura. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Finel Onset and Death disesse or condition of Shoulder an Gunshot Wound reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated aventa DUE TO (OR AS A CONSEQUENCE OF) resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 1 TV YES 2 - NO OF DEATH? 1 TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) tX YES 2 NO HOSPITAL OTHER: 4 Nursing Home 5 Residence 8 Sother (Specify) Inpatient 2 - ER/Outpatient 3 DOA on street 28d. DESCRIBE HOW INJURY OCCURED 27 MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 286. TIME OF INJURY OCY) AM 28c. INJURY AT 1 Natural 12-1-94 1 YES 2 NO BY 2 Accident 28s. PLACE OF INJURY — At home, tarm, street, tactory, office building, etc. (Specify) 281. LOCATION (Street and Number of Rural Route Number City or Town, State) 5 3/3 Deal Drive ETED 3 Suicide
4 Homicide 8 Could not be detarmined street 29a. CERTIFIER COMPL 1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, and due to the cause(s) end manner as stated. (Check only one) 2 😾 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as atlated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE ller hute 1100 2 0.1 M 1994 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Penn Street. Baltimore.

111

32. AUGISTRAR'S SIGNATURE

Maryland 21201

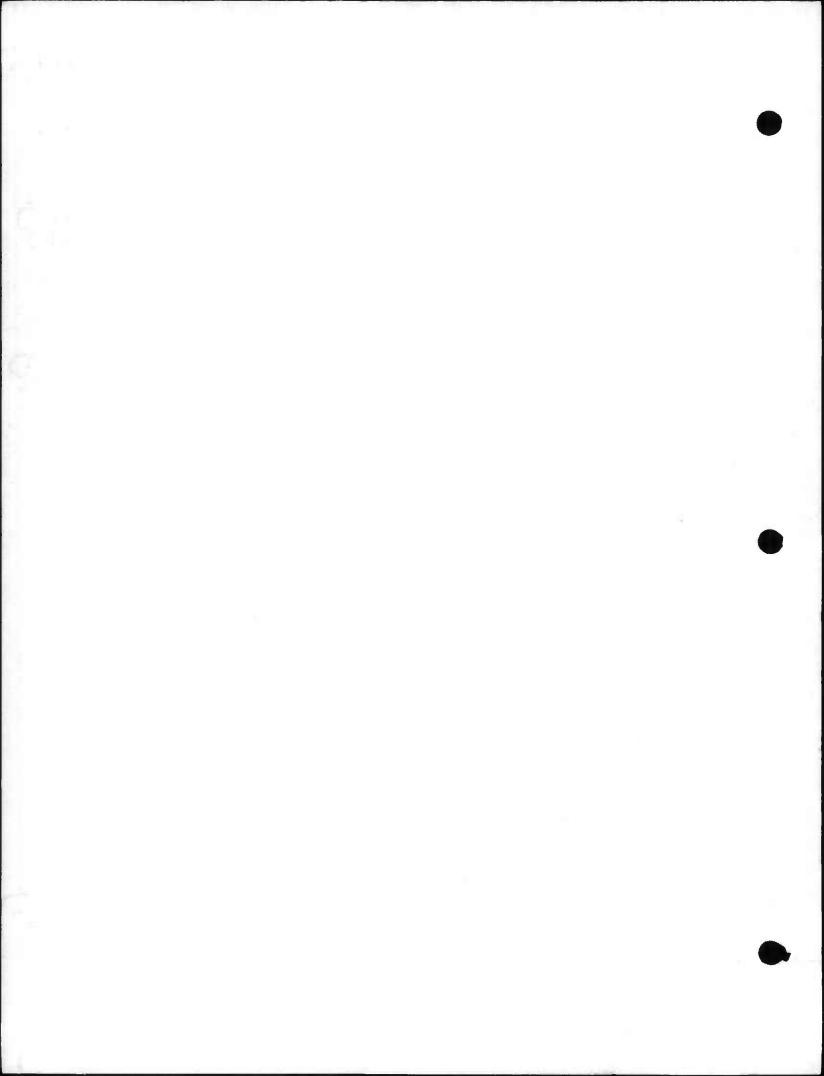


BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a notation after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
be filed within 72 hours after death with the State Dept, of Health and Mental Hygliene prior to burial, cremation, or removal.
IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

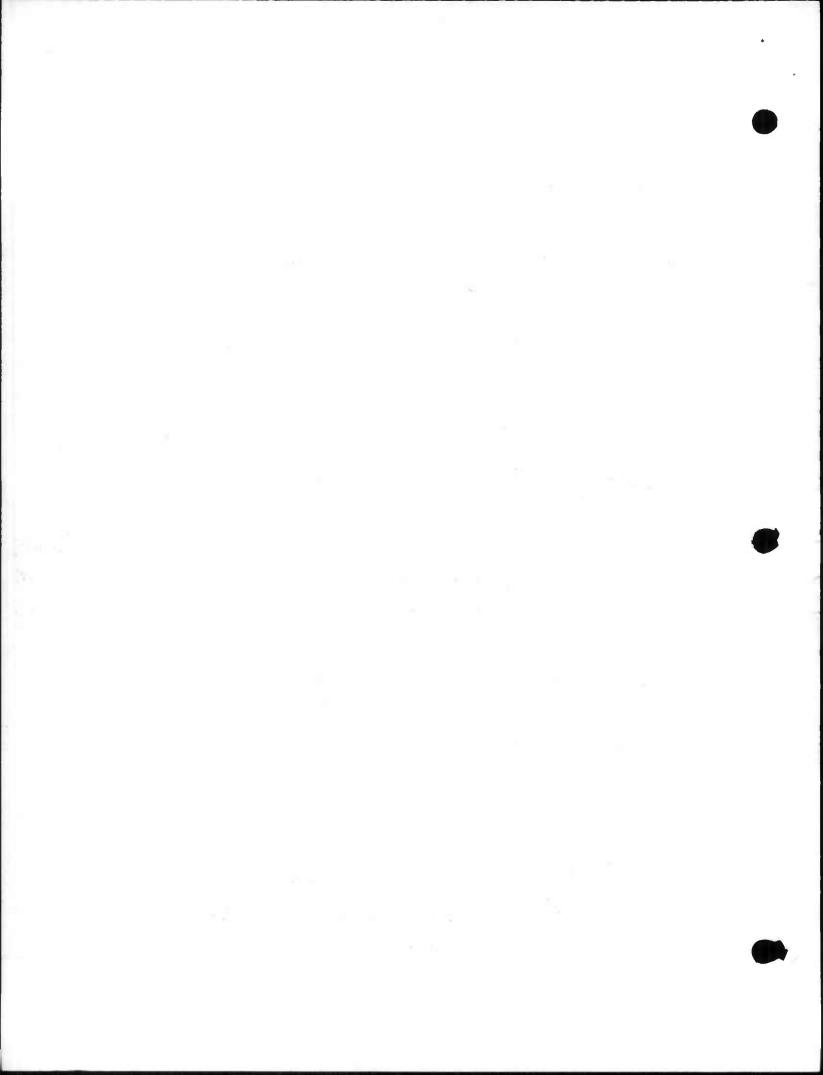
	FOR STATE REGISTRAR	STATE OF MARYL		IENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.							
	1. DECEDENT'S NAME (First, Middle, Last)			1	2. DATE OF DEATH	YEAR	3. TIME OF DEATH					
	Donald C.		W	hite	November)	16:23 AM						
8	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	THPLACE (State or Foreign					
	218-09-0259	1×2 M 2 D F 7	9 YRS. MO	NTHS DAYS HOURS MIN.	(Month, Day, Year) Mar. 25 19	915 M	aryland					
1	So. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH											
DIRECTOR	Shady Grove Adv	Shady Grove Adventist Hospital Rockville Montgomery										
l m	100. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10											
1 2	Md. Mont	gomery	Ger	mantown			LIMITS?					
7	Md. Montgomery Germantown 106. STREET AND NUMBER 109. CITIZEN OF WITH											
FUNERAL	20501 Greenfield Rd. 20876 U.S.A											
3	11. MARITAL STATUS	12. WAS DECEDENT EVER II	N U.S. ARMED	13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Yes	or No — 14. RA	CE - American Indian,					
	1 Never Merried 2 Merried	FORCES? 1 YES	2 NO ATES	If yee, specify Cuben, Mexic 1 YES 2 NO Specific No.			eck, White, etc.					
ВУ	3 Widowed 4 Divorced				.,		white					
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S USI	done during most of working	16b. KIND OF BUSI	NESS/INDUSTRY						
Ë	Elementary/Secondary (0-12)	College (1-4 or 5+)	ille. Do NOT use re	tired.)								
MP	11		Road i	nspector	Montgon		ounty					
	17. FATHER'S NAME (First, Middle, Last)				AME (First, Middle, Melden S							
H	Charles Ernest	White			Spect							
2	19e. INFORMANT'S NAME (Type/Print)			DRESS (Street end Number or Rural								
Ι' Ι	Anna M. Perry 20a. METHOD OF DISPOSITION			<u>Greenfield I</u>	Rd.Germant	own Mo	1.20876					
	10 Buriel 2 Cremation 3 Rem 4 Donation 6 Other (Specify)	ioval from State 20b	PLACE AND DATE OF D netery, crematory or other	placa)		ATION — City or						
			Monocac		12/7 Bea	llsvil	lle. Md.					
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hilton Funeral Home / P.O. 86											
	Barnesville, Md, 20838 23. PART I. Enter the dieeeses, or complications that caused the deeth. Do not enter the mode of dying, such as cerdisc or respiratory street, Approximates											
	23. PART I. Enter the dieeeses, or ahock, or heart fellure.	complications that caused List only one cause on a	d the deeth. Do not	enter the mode of dying, su	ch as cerdisc or respire	atory srrest,	Approximets					
1	IMMEDIATE CAUSE (Finel	A STATE OF THE PARTY OF THE PAR		A / 0. 1			Interval Between Onset and Death					
1 1	disease or condition ASPIRATION PNEUMONIA 2 DAYS											
	DUE TO (OR AS A CONSEQUENCE OF): LUING CANCER 1 YEAR											
2												
P A	If any, leading to immediate	cause. Enter UNDERLYING										
임	CAUSE (Disesse or Injury that initiated events	C. DUE TO (OR AS A	CONSEQUENCE OF):									
CERTIFICATION	resulting in deeth) LAST						į į					
		ď.										
AL	PART II. Other algolificant condition	e contributing to deeth b	out not resulting in t	he underlying ceuse given in	Part I. 24a. WAS AN A PERFORM		4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO					
8					1 TES 2	THO	COMPLETION OF CAUSE OF DEATH?					
MEDIC							1 YES 2 MO					
ä	DID TOBACCO USE	CONTRIBUTE TO	CAUSE OF E	DEATH YES NO	0 0							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		26. PLACE OF DEATH (C	heck only one)							
YSI	1 TES 2 NO	1 Inpetient 2 - ER/Outp		Nursing Home 5 Residence	8 Other (Specify)							
F	27. MANNER OF DEATH 1 Netural 5 Pending	(Month, Day, Year)	28b. TIME O	F 28c. INJURY AT WORK?	28d. DESCRIBE HOW IN.	JURY OCCURED						
à	1 Matural 5 Pending 2 Accident Investigation			M 1 YES 2 NO								
9	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, atc. (Spec	' — At home, ferm, stree cify)	t, factory, office	28f. LOCATION (Street an City or Town, Stete)	d Number or Rure	l Route Number,					
E												
릴				t the time, date and place, and du								
COMPLET	2 MEDICAL EXAMINE	R: On the basis of examination	n end/or investigation, is	n my opinion, death occured at th	e time, date end place, end	due to the cause	e(e) end manner se stated.					
BE C	296. SIGNATURE AND TITLE OF CERTIFIE	1 (Ahren)	29c. LICENSE NU	MBER	29d. DATE SIGNE	ED (Month, Day, Year)						
일		WIND		D32	407	D 11/1	9/94					
F	30. NAME AND ADDRESS OF PERSON WH						7 0					
	JOSEPH HAGGERTY	44808 PI	HYUCIANS	LANE HZ12	Kockville	MD	20850					
	31. DATE FILED (Month, Day, Year) UEC 0 7 19	94 32. REGISTRAR'S SIGN	ATURE									
	DEC 0 (13	Jua wa	west hardall									



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

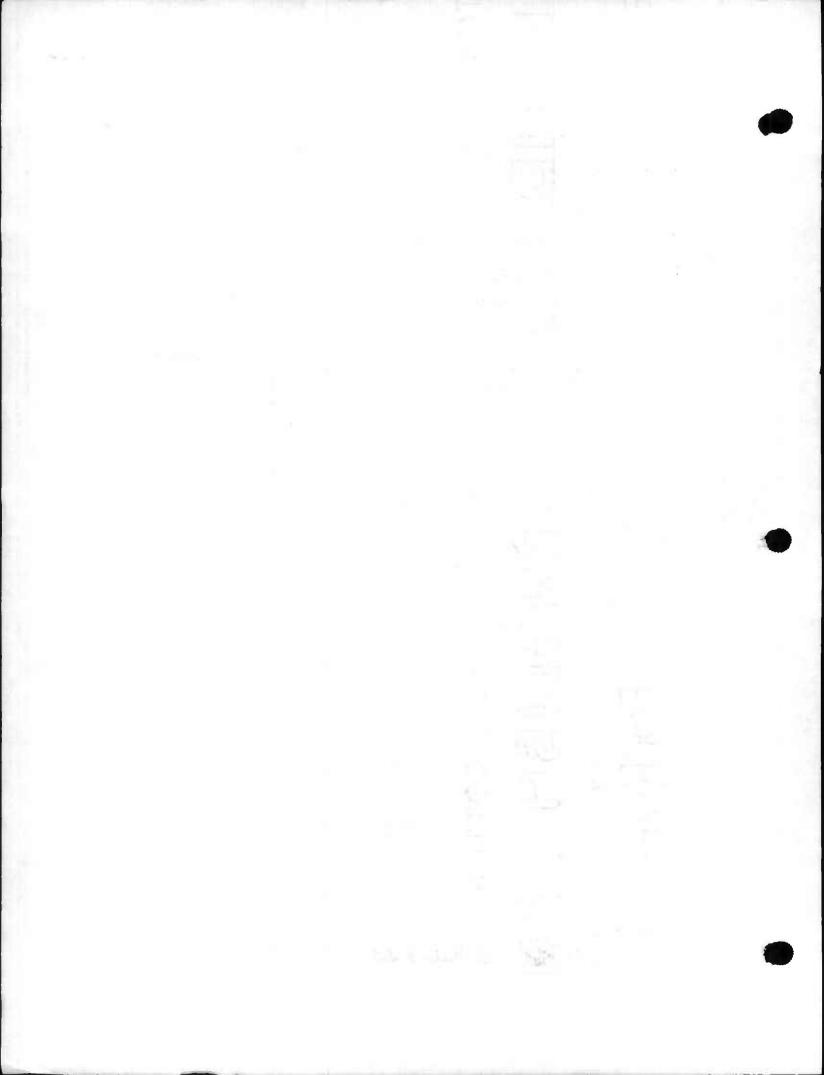
1 - FOR STATE REGISTRAR

		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH D	AY YEAR	3. TIME OF DEATH
		WOFFORD C.	WADE					<u>DECEMBER C</u>	1, 1994	5:15 Pm
9	1	4. SOCIAL SECURITY NUMBER 488-26-4815	1 M 2 - F	E (In yrs. lesi	YRS.	MONTHS DAY		Month, Day, Year) August 29,	1925 I	ATTHPLACE (State or Foreign unity) MISSOURI
2, 3 should	TOR	99. FACILITY NAME (If not institution, give THE JOHNS HOPKINS					MORE CITY		9c. COUNTY OF	DEATH
permit. Pages 1,	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT Florida	Y			y, TOWN OR LO				10d. INSIDE CITY LIMITS? 1 💢 YES 2 🗌 NO
	ERAL	100. STREET AND NUMBER 1485 Southeast M	erion Court				101. ZIP CODE 34952			F WHAT COUNTRY?
215-0020 attending physician. ise as the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 12 YE IF YES, GIVE WAR OR	S 2-KN	MED IO	If yes,	DECENDENT OF HISPA	ANIC ORIGIN? (Specify Yesan, Puerlo Rican, etc.)	BI	ACE — American Indian, ack, White, atc.
215-00 attending	ED B	15. DECEDENT'S ED		16a, DE	CEDENT'S	USUAL OCCUP	ATION	18b. KIND OF BU	ISINESS/INDUSTRY	
21 For L	E	(Specify only highest grad	College (1-4 or 5+)			work done during se retired.) 7e for		od Pharmac	eutical	Company
YLA by the be de	E COMP	17. FATHER'S NAME (First, Middle, Last) Woffard C. Wade					Eva Le	AME (First, Middle, Maiden	north and	
be retained ge 5 should e notified	TO B	19a. INFORMANT'S NAME (Type/Print) Dorothy M. Wade		196	485 S	ADDRESS (Street)	et and Number or Aura st Merion	Ct., Port	rn, State, Zip Code) St. Lu(34952 cie, Fla.
FORE FORE FORE FORE FORE FORE FORE FORE		20e. METHOD OF DISPOSITION 1		ob. PLACE A ematary, cre A I		OF DISPOSITION thar place) .S	(Name of		est Ches	Town, State
		21. SIGNATURE OF FUNERAL SERVICE L	CERNET			Ro	bert T. J	ones & Foa St., Newa	rd Funer	cal Home
H.O. BOX 68760 BALT th certificate be executed within 25 hours after death, the charge physician and completely filled in by the function of the physician of the physician of the companion of the charge of the	CERTIFICATION	23. PART I. Entar Me diseases, or shock, or heart failura. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	a. DUE TO (OR AS	CONSEG	OUENCE OF	1: 156 15	adacy		iratory arrest,	Approximate Interval Batwan Onset and Death IO COUNTY OF WARK SHOWN IN THE PROXIMATION OF
KECOKDS, v requires that the deal been signed by the att rt. of Health and Menta	MEDICAL	PART II. Other algorificant condition	y disease		1 ve	dise	25e	1 TYES	RMED?	46. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO
ITAL IITAL V: The law leate has b State Dept. Item 23	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT	OTHER:	ne)			
PHYSICIAL this certification with the	PHY	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	,	28b. TIM	E OF 28c. URY	INJURY AT WORK?	8 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCURED	
OR ATTENDING IDINECTOR: After hours after death Item 28 Is mail	TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28a. PLACE OF INJUI building, atc. (Sp.	RY — At hor	me, term, a			26f. LOCATION (Street City or Yown, State)		al Route Number,
AL DIR	COMPLE		ICIAN: To the best of my kno							e(s) and manner as stated.
TO THE HOSPITAL TO THE FUNERAL be filed within 72 IMPORTANT: If	BE	29b. SIGNATURE AND SOLE OF CERTIFIE	R				29c. LICENSE NU	LA803	29d, DATE SIGNI	ED (Month, Day, Year)
	ТО	30, NAME AND ADDRESS OF PERSON W	O COMPLETED CAUSE OF C	PEATH (ITEM	27) (Type,	Prince Stee	of The	ns Hatin	Post	me 21-251
		31. DATE FILED (Month, Day, 1964)	32. REGISTRAR'S SIG		. 00_		/	7	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	



	th. Page 6 may be retained by the hospital or attending physician.	eral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should	miner must be notified at once.
CONTRACTOR OF THE CONTRACTOR O	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a yours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2. 3 should be shown within 72 hours after death with the State Dect, of Health and Mental Hyolene prior to burial, cremation, or removal.	IMPORTANT. If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MAR	RYLAND / D CEF	EPART	MENT	OF H	EALTH DEAT	AND N		HYGIENI REG. NO.	E		
		ITTINGTON	WRIG	нт					2. DATE OF MONTH	DEATH DA	9 9	YEAR 4	3. TIME OF DEATH A
	4. SOCIAL SECURITY NUMBER 216-12-3413 98. FACILITY NAME (# not institution, gi	1 🗆 M 2 🚉 🏋	AGE (In yrs. last b	YRS.	IF UNDER 1	DAYS	HOURS	MIN.	7. DATE OF (Month, C DEC	lay, Year)	-03	8. BIRTHE Country	A.GO MD
OR			CENTER		AN	INAI	OLI	S			ANN	E A	RIINDEI.
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COU	INTY		10c. CITY,			ON						10d, INSIDE CITY LIMITS?
	MD ANN	E ARUNDEL		ANN	APOI								1 XXES 2 NO
ERAI	1022 MADISON	STREET				101.	214				10g. CITI	U.S	HAT COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EV FORCES? 1 IF YES, GIVE WAR		XX	11	yes, spe	NDENT O	F HISPAN	IIC ORIGIN? (n, Puerto Ric /:		or No	14. RACE	- American Indian, White, atc.
	15. DECEDENT'S I	EDUCATION	16a. DECE				N et of workin	7	16b. K	ND OF BUS	BINESS/IND	STRY	
COMPLETED	Elementary/Seogndary (0-12)	College (1-4 or 5+)	life. D	DOMI	retired.)						++++	+	
BE CO		HITTINGTON					Committee of	MAR		HEB	RON		
5	190. INFORMANT'S NAME (Type/Print) AGNES SHAR	PS	19b. (ADDRESS SAME				Route Number, E	City or Tow	n, State, Zip	Code)	
	26s. METHOD OF DISPOSITION Buriel 2 Cremation 3 F Donation 6 Other (Specify)	Removal from State	20b. PLACE AI	ANNI	OF DISPO	SITION DEC	(Name	-94	DATE		CATION — NAPO		m, State MD. 21401
	21. SIGNATURE OF FUNERAL SERVICE CHARLES E. H	- 1	Die	ks	20	US E	OF						o,md. 2140 DRIVE
CERTIFICATION	shock, or heart fallulimmediate CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR	AS A CONSECU	ENCE OF): net	2	Re	CTI	PON				Interval Between Onset and Death
AL CE	PART ii. Other significant condi	itions contributing to de	ath but not rea	suiting in	n tha Un	darlying	cause	jiven in	Part I. 2	4a. WAS AN		24b.	WERE AUTOPSY FINDINGS
MEDIC									_	PERFOI			AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICA EXAMINER?						ACE OF D	EATH (Ch	eck only one)				
YSIC	1 VES 2 NO	HOSPITAL:		DOA 26b. TIME				eldence	6 Other (Specify)			
	1 Natural 6 Pending	(Month, Day,	Yber)	INJU	JRY M	WO	RK?] NO	280, DEŞC	HIBE HOW	INJUNT OC	COHED	
TED BY	2 Accident Investigat 3 Suicide 6 Could not 4 Homicide determine	28e. PLACE OF IN building, etc.	JURY — At hom (Specify)	e, farm, s	treet, fact	ory, offic	•			ION (Street Town, State		r or Rural F	loute Number,
COMPLET	one)	HYSICIAN: To the best of my MINER: On the basis of exam) and manner as stated.
BE	29b. SIGNATURE AND TITLE OF CERT	TIFIER Coars	The .	5.			294 LIC	ENSE NU	MBER		29d. DAT	re SIGNED	(Month / Day, Year)
2	DONNED	WHO COMPLETED CAUSE	OF DEATH (ITEM	27) (Туре,	Print)	67	tore,	1	In	m	spo	Zir	2.403
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATURE	P	7.18								
	UEU-U-U-U-U-U-U-U-U-U-U-U-U-U-U-U-U-U-U	1984 /11/1	<u>चामानसम्बद्धाः</u>	- PARAM	a.la								DHMH-16 Rev 1/89



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DIVISION OF VITAL RECORDS, P.O. BOX 68/60	with
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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 213-28-96"1 CERTIFICATE OF DEATH REG. NO. James Olin Wilson 1. DECEDENT'S NAME (First, Middle, Last) 2, DATE OF DEATH 11 WILSON 05 8. BIRTHPLACE (State or Foreign Country) 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Your 1 M 2 - F DAYS Maryland permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Amapolis Anne Anande 10c. CITY, TOWN OR LOCATION 10a STATE 10b COUNT 10d. INSIDE CITY Fulton Roswell Georgia 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? by the hospital or attending physician. be detached for use as the burial-transit (30075 United States 280 Lakemont Drive 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 14. RACE — American Indian Black, White, etc. 1 Never Married 2 Married Specify: White BY 3 Widowed 4 Divorced 1947 - 1952 ED 15. DECEDENT'S EDUCATION tea. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Ш Computer Industry College (t-4 or 5+) Elementery/Secondary (0-12) COMPL Education / Marketing should be detached Marketing once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumeme) notified at Olin Wilson Eva Smith BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 10 Jean Kadel Wilson 280 Lakemont Drive Roswell, Georgia 30075 page 9 20a. METHOD OF DISPOSITION
1 Burial 2 Commation 3 Re 20b. PLACE AND DATE OF DISPOSITION (Nama of 20c. LOCATION - City or Town, State DATE must director. Ft. Lincoln Crematory 4 Donation 5 Other (Specify) 12/7/94 Brentwood, Maryland or other traumatic event, the medical examiner 22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home 21. SIGNATURE OF FUNERAL SERVICE LICENSEE funeral 147 Duke of Gloucester St. Annapolis, MD the or removal. 23. PART I. Enter the disesses, or complications that ahock, or heart fellure. Liet only one cause 3 not enter the mode of dying, such as cardiec or respiretory srrest, Approximete filled in I Interval Between IMMEDIATE CAUSE (Finel **Onset and Death** cremation, disease or condition recuiting in desth) and completely fill burial, cremation DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditione, DUE TO (OR AS A CONSEQUENCE OF) Hygiene prior to If sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events attending resulting in deeth) LAST the atten item 23 shows any injury, PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? signed by the 1 TES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO has be Dept. UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only 6 certificate h **EXAMINER?** HOSPITAL: OTHER 1 Inpetient 2 ER/Outpetient 3 DOA 1 TYES 2 NO me 5 Realdence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK?
1 YES 2 NO this cu 28b. TIME OF 28 is marked, 28d. DESCRIBE HOW INJURY OCCURED t Natural BY After t 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 3 Suicide 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED e 🗌 Could not be DIRECTOR: 4 Homicide TO THE FUNERAL DIRECTO be filed within 72 hours of IMPORTANT: If Item 21 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) end menner as stated. 2 MEDICAL EXAMINER: investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated. 296. SIGNATURE AND TITUE OF 29c. LICENSE NUMBER 29d. DATE SIGNED (Mgnth, Day, Year) BE 9 CAUSE OF DEATH (ITEM 27) (Type, 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

X

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to buriat, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3. TIME OF DEATH
	Carrie Bell Haymo	n maiden	name:	washin	gton	December 3	1994	4:10 p M
	4 SOCIAL SECURITY NUMBER			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTN	PLACE (State or Foreign
	4 262462525	1 XMX2 X F 8	7 YRS. "	NONTHS DAYS	HOURS MIN.	(Month, Day, Year) 6-12-190	7 Countr	GA.
	9a. FACILITY NAME (If not institution, give str			9b. CITY, TOWN C	R LOCATION OF DE		e. COUNTY OF D	
OR		-AAFB HOSP	ITOL A	AAFB 8	MED.G	. P.G.CO	P.G.	
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			TOWN OR LOCAT				10d. INSIDE CITY
DIRECTOR		P.G.		RAL P.		CLINTON		LIMITS?
1	MD 104. STREET AND NUMBER		1001		ZIP CODE		log. CITIZEN OF V	
ER/	6307 DUTROW CO	OURT			2073		U.S	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED			IC ORIGIN? (Specify Yea or	No- 14, RACE	- American Indian.
BY F	1 Never Married 2 Married	FORCES? 1 YES	ATES XX	If yes, spe	city Cuben, Mexicar 2 AMO Specify	n, Puerto Rican, atc.)	Speci	r, White, etc.
	3 Wildowed 4 Divorced						AFR	5 AMERICAN
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of		16a. DECEDENT'S U. (Give kind of wo life. Do NOT use	rk done durina mo	N st of working	16b. KIND OF BUSIN	ESS/INDUSTRY	
J.E	Elementary/Secondary (0-12)	College (1-4 or 5+)						
N C	!@ 12	???	HOMEM	IALLK	40 MOTHERIO MA	ME (First, Middle, Malden Sur	++++	
	THOMAS MILTON	WASHINGTO	NT.		MOLLY	HOLTON	mame)	
BE	19a. INFORMANT'S NAME (Type/Print)	WADIIINGTO		DDRESS (Street a		Noute Number, City or Town, S	State: Zip Code)	
5	JAMES W. HAYN	MON		SAME	AS 10		, Elp 5550)	1
	20a. METHOD OF DISPOSITION XXX Byriel 2 □ Cremetion 3 □ Remo	20b	PLACE AND DATE OF			DATE 20c. LOCAT	TION — City or To	wn, State
	4 Donation 5 Other (Specify)	val from State cem	AUREA H	TI.I CF	M12=12	=10-94 LA	AKELANI	FL.
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	1/1.	# PARTHE AN	D'AGDRESS OF FAC	ANNAPOLI	S. MD.	21401
	▶CHARLES E. H	ICKS 111	et XI'Z	HOUS	E OF HI	CKS 1922	FOREST	DRIVE
	23. PART i. Enter the diseases, or co	omplications that caused	the geeth. Do no	t enter the mo	de of dying, auch	as cerdiec or reepirat	ory arreet,	Approximate
	IMMEDIATE CAUSE (Finel	let only one ceuse on e	ech line.					Oneet and Death
	disease or condition resulting in death)	. Cardiopulm	onary fai	ilure				1
		DUE TO (OR AS A	CONSEQUENCE OF):					
NO	Sequentielly list conditions,	DHE 70 (OD 40 4	CONSEQUENCE OF:			=		
ATI	If any, leading to immediate cause. Enter UNDERLYING	DOE TO (OH AS A	CONSCOUENCE OF):					i 1
윤	CAUSE (Disease or injury that initiated evente	DUE TO (OR AS A	CONSEQUENCE OF):					<u> </u>
CERTIFICATION	resulting in deeth) LAST	L						
	PART II. Other aignificant conditions	contributing to death b		Alba a send a da la s		Sirve I dispense of the con-		
SAL	PART II. Other aignineant conditions	contributing to death b	ut not resulting in	the underlying	ceuse given in i	Pert I. 24s. WAS AN AU PERFORME	TOPSY 24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
Ē						1 TYES 2 🔀	NO	OF DEATH?
2	DID TOBACCO USE CONTR	IDLITE TO CALISE O	E DEATH VEC		UNCERTAIN			1 TYES 2 NO
IAN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		UNCERIAIN	1 1		
PHYSICIAN: MEDICAL	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 1 inpetient 2 □ ER/Outp		OTHER:	5 Residence	8 C Other (Specify)		
<u>¥</u>	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJ	JRY AT	2ad. DESCRIBE HOW INJU	JRY OCCURED	
BY F	1 Natural 5 Pending 2 Accident Investigation	(MOIRIT, Day, Ibar)	injui		RK? ES 2 NO			
	3 Suicide 8 Could not be	28e. PLACE OF INJURY building, atc. (Spec	— At home, ferm, str	eet, factory, office		28f. LOCATION (Street and City or Town, State)	Number or Rural F	loute Number,
COMPLETED	4 Homicide determined							
7	29a. CERTIFIER (Check only 1 CERTIFYING PHYSIC	IAN: To the best of my knowl	edga, death occurred	at the time, data	and place, and due	to the cause(s) and manner	r as stated.	
NO.	one) 2 MEDICAL EXAMINER	t: On the basis of examination	and/or investigation,	In my opinion, de	ath occured at the	time, deta and placa, and d	lue to the ceuse(s) and manner se stated.
BEC	29b. SIGNATURE AND TITLE OF CERTIFIER	1111			29c. LICENSE NUM	BER 25	9d. DATE SIGNED	(Month, Pay, Year)
면 일	Kinold	Water	MD		1672	73 NY	12/	3/94
-	30. NAME AND ADDRESS OF PERSON WHO		ATH (ITEM 27) (Type, P	rint)		9 Medical G		
	Ronald Watts, MC, 1	JSAF			A	ndrews AFB	MD 203	31-6600
ŀ	31. OATE FILED (Mogth, Day, Year) DEC 0 7 19	32. REGISTRAR'S SIGN						
	0 , 13.	JE Jalla d'Eu	alsor Reveal					

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examiner must be notified at once.	IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
f.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
e funeral director, page 5 should be detache	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached
death. Page 6 may be retained by the hosp	TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hosp
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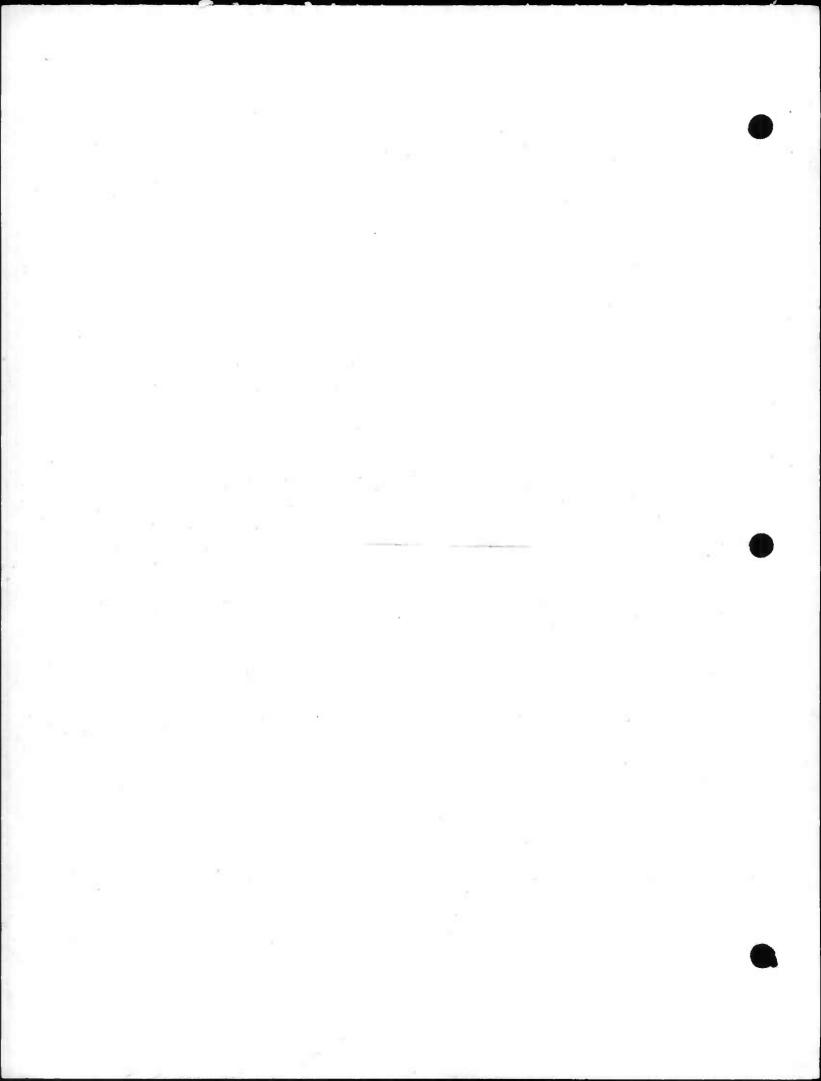
,	mended FOR 1-STATE REGISTRAR		STATE OF I	194 MARYLAND C	MR I DEPAR ERTIF	RTMEN	OF H	EALTH DEAT	AND		HEG. N	NE io.	4	37132
	1. DECEDENT'S NAME (First,	065	6. SEX	Thomas 6. AGE (In yrs. In		7		IF UNDER	atsor	MOR	1/1	DAY 9	YEAR	3. TIME OF DEATH
	220-07-3950		1 M 2 □ F	85	YRS.	MONTHS	DAYS	HOURS	MIN.	Feb	e of BIRTN oth, Day, Year) ruary	1909	Coun	land
	9a. FACILITY NAME (If not in.	stitution, give s	treet and number)			9b. CIT	, TOWN C	R LOCATI	ON OF DI			_	UNTY OF	
TOR.	Washington A		lst Hospi	tal		Tako	oma l	Park				Mon	tgom	ery
DIRECTOR	10a. STATE	10b. COUNTY	,		10c. CIT	ry, town	OR LOCAT	ION						10d. INSIDE CITY
ā	Maryland	Montg	gomery		Silv	ver S	Sprin	ng						1 X YES 2 NO
3AL	10e. STREET AND NUMBER			315				ZIP COD				10g. CI	TIZEN OF	WHAT COUNTRY?
NEF	9305 Ocala S	treet						20901					USA	
BY FUNERAL	1 Never Married 2 💢 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2 MAR OR DATES	INO		If yes, sp	elfy Cuba 2 NO	n, Maxica	in, Puert	NN? (Specify o Rican, atc.)	Yes or No—	Blac	E — American Indian, ck, White, atc. city: White
LEO	15. OEC (Specify only	EDENT'S EDU	CATION completed)	(ECEDENT'S	work done	during mo	N st of working	ng	11	Bb. KIND OF I	BUSINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0	1-12}	College (1-4 or 5	+}	ephor			oin-		7	alanh	om o C		
OM	17. FATNER'S NAME (First, M.	liddle, Last)		ITEL	.epiioi	16 16	CIIII			-	eleph		_	пу
BE C	William V.	Watson	, Sr.					Mary	Le	e Ra	wling	S		
2	19a. INFORMANT'S NAME (T	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Paleti								mber, City or 1			
-	James Watson										Fred			
	20a, METNOD OF DISPOSITE 1 ☑ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	n 3 🗆 Rem	ovat from Stata	ROCK.	EAND DATE	OF DISPO	SITION /Na	me of		D/	TE 20c.	LOCATION -	- City or T	
			and the same of th	/	Creer							hingt		
	21. SIGNATURE OF FUNERA 23. PART I. Enter the di	h 1	. Hil	Mell	2	F1 50	name anci	s J.	ss of Co.	ilin y Bl	s Fun	eral :	Home .Spr	, Inc. . MD 20901
	23. PART I. Enter the di	isesses, or cant failura.	complications the	All caused the c	death. Do	22. F1 5(NAME ANCIDED OF THE PROPERTY O	s J.	ss of Co.	ilin y Bl	s Fun	eral :	Home .Spr	, Inc.
NOIL	23. PART I. Enter the di shock, or hi IMMEDIATE CAUSE (Fin disease or condition	isesses, or cant failura.	complications that List only one can a	of caused the cause on each life	death, Do na.	FI 50 not enter	NAME ANCIDOR THE MO	D ADDRE	ss of FA CO Sity Ing, suc	ELLITY Ilin y Bl	s Fundavd.W.	eral ;	Home .Spr	, Inc. MD 20901 Approximate Interval Between Onset and Deatt
	23. PART I. Enter the di shock, or hi IMMEDIATE CAUSE (Fin disease or condition resulting in death)	isesses, or call its and its a	a. Due to OUE TO C. AC	pl caused the cuse on anch lin	death. Do ha.	Pri Go	NAME AND TAILCE	D ADDRE	ss of FA CO Sity Ing, suc	ELLITY Ilin y Bl	s Fundavd.W.	eral ;	Home .Spr	, Inc. MD 20901 Approximate Interval Between Onset and Deatt
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CERT	23. PART I. Enter the dishock, or himmediate CAUSE (Findissess or condition resulting in death) Sequentially list conditi if any, leading to immeceuse. Enter UNDERLY CAUSE (Disease or injuthet initieted eventa resulting in death) LAS PART II. Other eignifica	lacesses, or cart failura. lons, diate ling liny. T	a. DUE TO OUE TO d	POUNTER DORAS A CONS O (OR AS A CONS O (OR AS A CONS O (OR AS A CONS O (OR AS A CONS O (OR AS A CONS O (OR AS A CONS O (OR AS A CONS	death. Do na.	PF:	NAME AN CIO	DI ADDRE S J. IIVE I I I I I I I I I I I I I I I I I	SS OF FACTOR CO.	Part I.	24a. WAS PERI	AN AUTOPS:	Home .Spr	Approximate Interval Between Onset and Death 2 hours 3 days 3 days
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11/30/94 D12582 mo LETED ONUSE OF DEATN (ITEM 27) (Type, Print) 7600 Carroll Alenva ICKOME Park 20912 fred 31. DATE FILED (Month, Day, Year)

1994

Like Davidson-Randall

	1. DECEDENT'S NAME (First, Middle, Last	liener			ICATE OF		2. DATE OF	DEATH DAY		TIME OF DEATH 3:30 P
	4. SOCIAL SECURITY NUMBER 114-01-6090	5. SEX	6. AGE (In yrs. in	yrs.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF E (Month, Da	ly, Ybar)	8, BIRTNPLA Country)	NCE (State or Foreign
OR	9e. FACILITY NAME (# not institution, give Hebrew Home of (ashingto	on	96. CITY, TOWN ROCKV	or location of D		9c. COUN	tgomer	Н
DIRECTOR	Maryland Mor	ntgomery			y, town on Loc ckville	ATION				d, INSIDE CITY LIMITS? YES 2 NO
FUNERAL	100. STREET AND NUMBER 6121 Montrose Ro	oad			11	20852		US.		T COUNTRY?
B	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced		NT EVER IN U.S. A I YES 2 5 MAR OR DATES		If yea, a	CENDENT OF NISPA pecify Cuban, Maxic S 2 NO Speci	en, Puerto Ricar		Black, W	American Indian, hita, atc. Vhite
LETED	15. DECEDENT'S ED (Specify only highest gra- Elementary/Secondary (0-12)			Give kind of a le. Do NOT us				ID OF BUSINESS/IND	USTRY	
COMPLET	12 17. FATHER'S NAME (First, Middle, Last)			Homen	naker	18. MOTNER'S N.	AME (First, Midd)	1 Home	Carama	\ \
TO BE (Louis Greenberg 19a. INFORMANT'S NAME (Type/Print)	**				and Number or Rural	Route Number, (wn Maiden City or Town, State, Zip	Code)	
	Faylee Hydorn 20a. METNOD OF DISPOSITION 1 Sp Burlel 2 Cremation 3 Re	moval from Stata	20b. PLACE		OF DISPOSITION (A		Freder	CKSburg,	-	
	4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE		Beth		22. NAME /	and address of F	CILITY	Paramus 1 Directi		ersey
	23. PART I. Enter the diseases, or	complications the	at caused the d	leath. Do r	1091	ROCKVIII	e Pike	, Rockvil	le, M	20852
	shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. State only one ca	Le o	10.	MYOC	ARDIAL INF				Interval Batwe Onset and Dec
LION	Sequentially list conditions, if any, leading to immediate	b	O (DR AS A CONSI							
RTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	cDUE TO	OR AS A CONSI	EOUENCE O	F):					
MEDICAL CE	PART II. Other eignificant conditions of the state of the	ons contributing to	death but not	resulting	in the underlyli		1/2211	NAS AN AUTOPSY PERFORMED? YES 2 NO	AM CO	RE AUTOPSY FINDING ALLABLE PRIOR TO MPLETION OF CAUSE DEATH?
ш	DID TOBACCO USE	CONTRIBUTI	E TO CAU	SE OF					1 [YES 2 NO
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	ER/Outpetlent	3 🗆 OOA	OTHER:	ne 5 Residence		pecify)		
			T INI HINDA	28b. TIM		JURY AT ORK? YES 2 NO	28d. DESCRI	BE NOW INJURY OCC		
BY PHYSICIAN: ME	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation		Day, Year)						or Rural Route	a Number,
PHYSICIAN:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not b datarmined	(Month, I	Day, Year)		M 1		281. LOCATIO City or To	own, State)		
ETED BY PHYSICIAN:	1 Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not b 4 Nomicide 8 datarmined	(Month, I	Oey, Year) OF INJURY — At It, etc. (Specify) I my knowledge, of	leath occurr	street, factory, offi	ca is and place, and du	City or To	own, State) a) and manner as state		d manner as stated.
BE COMPLETED BY PHYSICIAN:	1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not b detarmined 29a. CERTIFIER (Check only) CERTIFYING PNY	28a. PLACE obuilding SICIAN: To the best of NER: On the bests of the b	Oey, Year) OF INJURY — At It, etc. (Specify) I my knowledge, of	leath occurr	street, factory, offi	ca is and place, and du	City or To	own, State) a) and manner as state place, and due to the	e cause(a) an	od manner as stated.
COMPLETED BY PHYSICIAN:	1 Natural 5 Pending Investigation 3 Suicide 8 Could not b datarmined 29. CERTIFIER (Check only one) 2 MEDICAL EXAMI	28a. PLACE obuilding SICIAN: To the best of a	Dey, Year) OF INJURY — At h., etc. (Specify) If my knowledge, casamination and/or	leath occurr r investigatio	street, factory, offi and at the time, dar on, in my opinion,	a and place, and du	City or To	own, State) a) and manner as state place, and due to the	e cause(a) an	



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

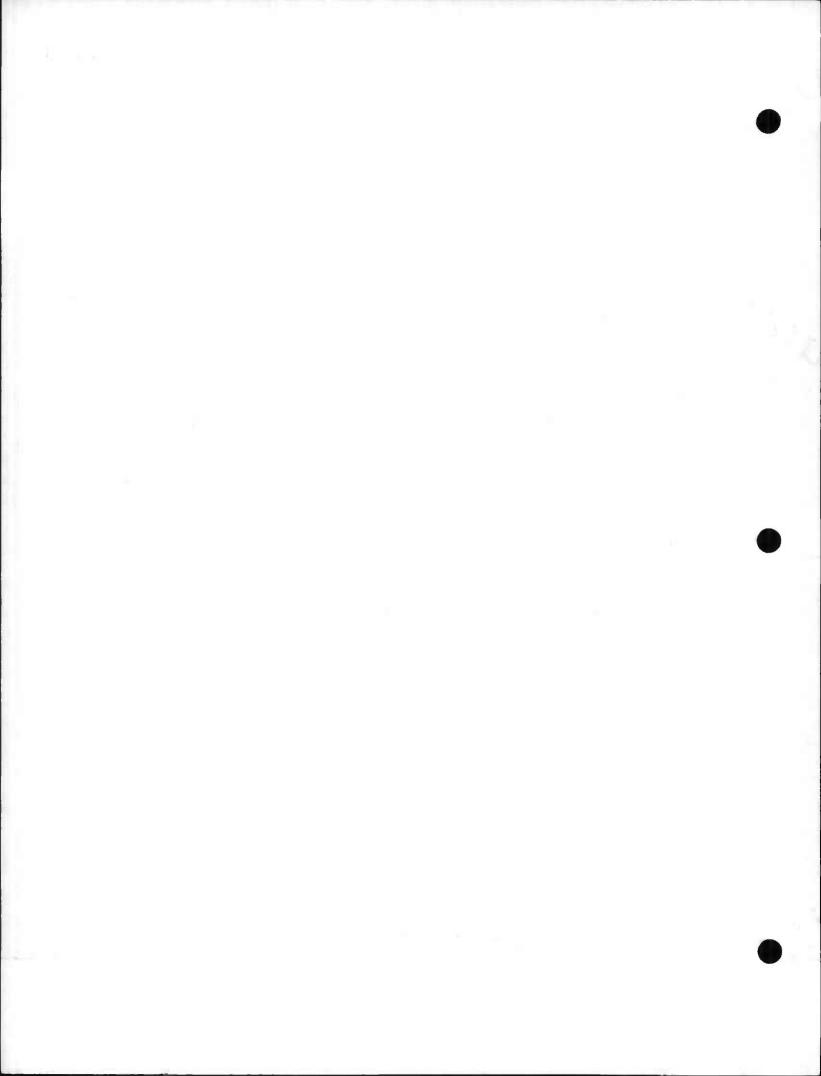
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. The hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Oept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERI	rific/	ATE OF	DEATH	REG. NO	١,			
	1. OECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH			3. TIME OF DEATH	
- 0	Edwar	rd	W.	wi	lliam	IS	NOVE MEET	AY The	YEAR	1630 Bu	
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. lest birth		UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	27		PLACE (State or Foreign	
		1½ M 2 □ F			THE DAYS	HOURS MIN.	(Month, Day, Year)	0.45	Country	γ)	
- 1	218-38-7523)T 41				Dec. 3,1			aryland	
_	9a. FACILITY NAME (If not institution, give a				CITY, TOWN	OR LOCATION OF D	EATH	9c. COL	JNTY OF OE	EATH	
DIRECTOR	Shady Grove Ad	lventist	Hospita	1	Roc	kville		Me	MONTGOMERY		
5	RESIDENCE OF DECEDENT							1	51110	OFILIKI	
#	10a. STATE 10b. COUNT		100	c. CITY, TO	WN OR LOCA	TION				10d. INSIDE CITY LIMITS?	
ā	Maryland Mont	gomery		Ga	ither	sburg			- 1	1 TES 2 NO	
7	10e. STREET AND NUMBER					. ZIP CODE		10g. CIT	IZEN OF W	HAT COUNTRY?	
3	9849 Brookride	re Court				20879			U.S		
FUNERAL	11. MARITAL STATUS										
리	1 Never Married 2 Married	12. WAS OECEDENT E FORCES? 1			13. WAS DEC	ENDENT OF HISPA ecity Cuben, Maxic	NIC ORIGIN? (Specify Year, Puerlo Rican, atc.)	s or No	14. RACE Black	American Indian, White, alc.	
B	3 Widowed 4 Divorced	IF YES, GIVE WAR				2 NO Specif				Black	
		1960-19	66						<u> </u>		
Ħ	15. OECEDENT'S EDU (Specify only highest grade	CATION completed)	18a. OECEDE	NT'S USU	AL OCCUPATION done during mo	ON set of working	16b. KIND OF BU	SINESS/IN	DUSTRY		
	Elementary/Secondary (0-12)	College (1-4 or 5+)	He. Do N	IOT use ret	ired.)	or or working					
립	12th		Lab	ore:	r		Home	Impi	rovei	ment	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S N	ME (First, Middle, Malden	-	. 01		
	George W. Wi	lliame				The state of the state of					
BE		TTTUIIS	-				ia Washi			·	
2	19a. INFORMANT'S NAME (Type/Print)		19b. MA	ILING ADD	ORESS (Street a	and Number or Rural	Route Number, City or Tox	vn, State, Zi	p Code)	20879	
	Mildred N. Wil	liams (w	ife) 98	49 1	Brook	rige Ct	., Gaith	ersk	ourg	, MD	
- 1	20a. METHOD OF DISPOSITION		20b. PLACE AND D	ATEOFDI	SPOSITION /No	ame of	DATE 20c. LC	CATION -	- City or Toy	wn. State	
- 1	12 Burlet 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	ioval from State	Stern Cramator	Y Solher E	Chur	ch Cem	12/1 B	OV.	- MI	0	
- 1	21. SIGNATURE OF FUNERAL SERVICE LI	CENSE				ND ADDRESS OF FA		Oyus	5 , FII		
		77	1		SNO	WDEN FI	NERAL HO	ME.	PA		
	DI DEE !	1 mor	nder	_			MD 208		1 . 11.	*	
	23. PART I. Enter the diseeses, or	complications that c	aused the death	Do not a	enter the mo	de of dulpo en	h se cardino or man	S U		Approximate	
	shock, or heart failure.	List only one cause	on esch iina.			do or dying, suc	in se condition of feep	matory a	Toot,	Intervsi Between	
	IMMEDIATE CAUSE (Finsi				, ,		,			Onset and Death	
Į.	disesse or condition resulting in death)	s. Acute DUE TO (OF	11.100	unn	1/4/	In Pan	rtipu			30 win	
	A STATE OF THE STA	DUE TO (OF	AS A CONSEQUEN	CE OF):			- []				
-		A .	/							1/2000	
ō	Sequantisity list conditions,	b. TYPE TO (OF	R AS A CONSEQUEN	CE OFI						1/24/5	
CERTIFICATION	if sny, leading to immediata cause. Enter UNDERLYING	0	1	. /							
0	CAUSE (Disease or injury	a ICENA	1 FAI	101	E					VEAPS	
1	that initiated eventa	DUE TO (OF	R AS A CÓNSEOUEN	CE OF):							
H	resulting in death) LAST	d									
	DART II ON THE STATE OF THE STA										
EDICAL	PART ii. Other significant condition	na contributing to de	ath but not reaul	ting in th	ne undariyin	g cause given in	Part i. 24a. WAS AN		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
2							1 _ YES :			COMPLETION OF CAUSE	
								20,10		OF DEATH?	
Σ	DID TORACCO LICE	CONTRIBUTE	TO CALLES	OF 5	EAT!!	VEC CO 114	<u></u>			1 TYES 2 NO	
Z	DID TOBACCO USE	COMIKIROIF	TO CAUSE	Or D	-						
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		T 07		LACE OF DEATH (C	neck only one)				
S	1 TYES 2 NO	1 Inputient 2 K E	R/Outpatient 3 🗆 D	OA 4 [HER: Nursing Hon	ne 5 🗆 Rasidenca	8 Other (Specify)				
PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF IN.	JURY 281	. TIME OF	28c. IN.	URY AT	28d. DESCRIBE HOW	INJURY OC	CUREO		
	1 M Netural 5 Pending	(Month, Day,	Year)	INJURY		YES 2 NO					
B	2 Accident Investigation	40. 01.407.07.0							-		
0	3 Suicide 8 Could not be	building, atc	NJURY — Al home, fi (Specify)	arm, stree	t, factory, offic	•	281. LOCATION (Street City or Town, State		er or Rural A	oute Number,	
COMPLETED	4 Homicide determined										
31	29a. CERTIFIER	ICIAN: To the heat of	knowledge death o			Carlos Street		100			
P	(Check only one)										
Ö	2 MEDICAL EXAMINE	On the basis of axan	lination end/or invest	ilgation, in	my opinion, o	leath occured at the	time, data and place, a	nd due 10 1	he cause(s)	and menner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIE	R	*			29c. LICENSE NU	MBER	29d. DA	TE SIGNED	(Month, Day, Year)	
H	Hann MI	0	1000 100	10		1 1-1	2117	11		1.40= 400	
임	30. NAME AND ADDRESS OF PERSON WE	TO COMPLETED CAUSE	OF DEATH STATE	7	el.	4/	4/	Na	VERD	05125,1494	
.	CO A A	Symmetries Gause	DEATH (ITEM 27)			1.	11 - 1	,			
	7401 MET	TICAL (GNYET	1 11	P. P.	chuil	E Md	2	08	50	
	31. DATE FILED (Month, Day, Year)	32. AEGISTRANS	signature Rand		11						
	1101 6 8 1994	June Da	Jacob - Marion								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

er death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	ral.	examiner must be notified at once.	
TO THE HOSPITAL DARTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	1 - FOR STATE OF MARYLAND / CE		ENT OF H		MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	Christopher Paul Wiegmann				Nov. 24	1994 YEAR	5:30 AM M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. less	//	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign
	215-12-3257 ¹፟⊠ м ² □ ғ 72	YRS. MON	ITHS DAYS	HOURS MIN.	Mar. 17.	1922 M	aryland
	9e. FACILITY NAME (If not institution, give street end number)	9b.	CITY, TOWN O	R LOCATION OF DE		9c. COUNTY OF	
9	12603 Darlenen St.		Largo			Prince	George's
<u> </u>	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY	10c CITY TO	OWN OR LOCAT	ON			
DIRECTOR	Maryland Prince George's			ON			10d. INSIDE CITY LIMITS?
	100. STREET AND NUMBER	Larg		ZIP CODE		100 CITIZEN OF	1 YES 2 XNO WHAT COUNTRY?
ER/	12603 Darlenen St.			20772		U.S.A	
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARI	MED	13. WAS DECI		IIC ORIGIN? (Specify Yes		E — American Indian, ck, White, etc.
	1 Never Married 2 Merried FORCES? 1 YES 2 N FYES GIVE WAB OR DATES 1943-1971	10	II yes, spe		n, Puerto Rican, etc.)	Blac Spe	
Э ВУ							White
COMPLETED	(Specify only highest grade completed) (Gi	ve kind of work	AL OCCUPATIO		16b. KIND OF BUS	SINESS/INDUSTRY	
빌	Elementery/secondary (0-12) College (1-4 or 5+)	Do NOT use ret	,	4.			
Ž	17. FATHER'S NAME (First, Middle, Last)	rot. Mar	ster Sg		ME (First, Middle, Maiden	ir Force	
	Frank Wiegmann					Surneme)	1
BE		MAILING ADD	ORESS (Street as		rine Rapka Poute Number, City or Town	n State Zin Code)	
임					Springfield		ì
	20s. METHOD OF DISPOSITION 20b. PLACEA	NODATEGED	SPOSITION (Nat	ne of	DATE 200 100	CATION - City or 1	own, State
	4 Donation Other (Specify) Cemetery, cref	netory or other p	Vationa	1 Cem.	11/30/94	Arl. V	а.
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AN	D ADDRESS OF FAC	CILITY		
- 8	(1) X Trace		3001	gion run N Fairf	neral Home fax Dr., An	el Vo	22202
CERTIFICATION	ahock or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUENCE OF):	CAN	COR			Interval Between Onset and Death
PHYSICIAN: MEDICAL	PART II. Other algnificant conditions contributing to death but not re				Part I. 24s. WAS AN PERFOR 1 TYES 2	MED?	b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			ACE OF DEATH (Che			
XSI	1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3		HER: Nursing Home	5 Residence	6 Other (Specify)		
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 1 Accident Investigation	28b. TIME OF INJURY	WOI	IRY AT RK? ES 2 NO	28d. DESCRIBE HOW H	NJURY OCCURED	
a	3 Suicide S Could not be determined 28e. PLACE OF INJURY — At hot building, atc. (Specify)	me, farm, street	t, factory, office		281. LOCATION (Street e City or Town, Steta)	and Number or Rural	Route Number,
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, de MEDICAL EXAMINER: On the best of examination end/or in						e) end menner se stated.
TO BE C	296. SIGNATURE AND TITLE OF CENTIFIES MADE NAT)		29c. LICENSE NUN	044946	29d. DATE SIGNE	(Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 100 2 8 1994 34. Davidson—100	ni) G		TAZE	VERL ST.	ARINGR	N, UM 22203
	The same of the sa	milwan					

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be field within 22 hours after death with the State Uppit, of Heath and Mental Hyghee photor to burial, cremation, or removal.	. I TOWN TO IN THE PARTY OF THE PARTY OF THE TRANSPORT OF THE PROPERTY OF THE
THE HOSPITAL THE FUNERAL (Filed within 72 h	Unioni. II

	FOR 1 . STATE	STATE OF N	MARYLAND /	DEPAR	TMEN	T OF H	EALTH	AND I	MENTAL	HYGIFN	F		3710	•
	REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest)		CI	ERTIF	ICAT	E OF	DEAT	ГН	2. DATE O	REG. NO	AV .	YEAR	3. TIME OF DEA	
		5. SEX 1 M 2 F	NTER 6. AGE (In yrs. Ins		# UNDE	R 1 YEAR DAYS	IF UNDER	MANA	7. DATE OF	Day, Year)		Country	7:12 PLACE (State or F	
TOR	9a. FACILITY NAME (If not institution, give stre NATIONAL LUTHE) RESIDENCE OF DECEMENT					y, town o		ATION OF DEATH 9c. COUNTY OF DEATH						0.
DIRECTOR	MARYLAND BALT	IMORE (CITY	10c. CIT		OR LOCAT	IMORE 10d, INSIDE CITY LIMITS?							
FUNERAL	100. STREET AND NUMBER 5717- EDMONDSON AVE. 100f. ZIP CODE 21228											.S. A	HAT COUNTRY?	
ВУ	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	13.	WAS DECI If yes, spe 1 YES	ENDENT OF	F HISPAN n, Mexica Specify	IIC ORIGIN? n, Puarto Ric	(Specify Yes	or No-	14. RACE Black Specifi	American Indi White, atc.				
COMPLETED	15. OECEDENT'S EOUCA (Specify only highest grade or Elementary/Secondary (0-12)) (Gi	CEDENT'S two kind of to Do NOT us	vork done se retired.)	CCUPATIO during mos	N st of worldn	g		IND OF BUS			ΣE	
BE CON	17. FATHER'S NAME (First, Middle, Last) CHARLES E. II	FERT							ME (First, Mic					
TO E	199. INFORMANT'S NAME (Type/Print) REV.DR. REICHARI	D	191	701	ADDRES	s (Street or EIRS	DR	or Rural F IVE	ROC	City or Town	LE,	MD.	20850	
	20e. METHOD OF DISPOSITION 1 St Burlet 2 Cremetion 3 Removal from State 4 Donation S Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ZION LUTH CHURCH CEM 1 1 / 28 MIDDLETOWN, MD													
	21. SIGNATURE OF FUNERAL SERVICE LIGHT	Dong			1		NG (co.	, INC.					
	PART I. Enter the diseases, or shock, or heart fellure. Unimmediate CAUSE (Final disease or condition	Inplications that at only one day			ot enter	the mod	de of dyli	ng, suct	h aa cerdia	c or reapl	ratory arr	est,	Approxim interval B Onset and	etween d Death
z	resulting in death) a.	DUE TO	OR AS A CONSEC	OVENCE OF	are	of E	an t	em 1 F	ail	(, , 0			10	fe .
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	A	OR AS A CONSECUTION AS	PUENCE OF	1:	tie	Cont	ne	eg A	s Con	n Des	eec		
MEDICAL C	PART II. Other significant conditions.	contributing to	deeth but not re	eaulting I	n the u	nderlylng	ceuse g	Iven in I	المممد	In. WAS AN PERFOR	MED7		WERE AUTOPSY FI AMAILABLE PRIOR COMPLETION OF (OF DEATH?	TO
AN: ME	Carolidaries	Jhux &	Tosis,	H	4 m	er	lei	152	in			- 1	1 YES 2	NO
PHYSICIAN:	1 YES 2 AND	HOSPITAL:		□ DOA	OTHE 4 Nur				6 Other (S	Specify)				
ВУ РН	27. MANNER OF GEATH 1 Natural 5 Pending 2 Accident Investigation	28a. OATE OF (Month, Da	y, Yber)		URY M		IRY AT RK? E\$ 2 [NO	28d. DESCF					
ETED.	3 Suicide 6 Could not be detarmined	building, a	INJURY — At hor itc. (Specify)							lown, State)			oute Number,	
COMPLETED	(Check only one) 2 MEDICAL EXAMINER:												end manner ee s	tated.
296. SIGNATURE AND TITLE OF CENTURE 296. SIGNATURE AND TITLE OF CENTURE 296. LICENSE NUMBER D 3 66/8									29d. DATE	SIGNEO	21/9	4		

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

DR. CHRISTOPHER SCHEMM- 9701- VEIRS DR., ROCKVILLE, MD.

Day.

TO BE COMPLETED BY FUNERAL DIRECTOR

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

								9	4 3	1131	
1 - FOR STATE REGISTRAR	STATE OF MARY		PARTMEN				MENTAL HYGIEN REG. NO.	E			
1. DECEDENT'S NAME (First, Middle, Lest)	10 20 0x						2. DATE OF DEATH			TIME OF DEATH	
Anme	B Wal	Ker	-				November 3	25	1994	1500 P.H	
		(in yrs. last birtho	BACACTIAN.	DAYS	IF UNDER 2	4 HRS.	7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign Country)				
	1 M 2 X F	68 YR	S. MONTHS	DAYS	HOURS	MIN.	Oct. 31,19	926		on, GA.	
9a. FACILITY NAME (If not institution, give stre			9b. CIT	Y, TOWN O	R LOCATION	N OF DE	ATH	9c. COU	INTY OF DEAT	тн	
Washington Advent	tist Hospita	al		Takon	na Par	rk		Mo	ontgom	nery	
10a. STATE 10b. COUNTY		10c.	CITY, TOWN	OR LOCAT	ION				10	Od. INSIDE CITY	
V1-1 P-4								LIMITS? YES 2 NO			
10a. STREET AND NUMBER	se ocorge s		пуа		ZIP CODE			10g. CIT		AT COUNTRY?	
6116 Rosedale Dr					2078	32		Ur	nited	States	
	12. WAS DECEDENT EVER FORCES? 1 YES		13				IIC ORIGIN? (Specify Years, Puerto Rican, etc.)	or No-	14. RACE -	- American Indian, Vhita, etc.	
1 Never Merried 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR				2 21 NO				Specify:	Black	
15. DECEDENT'S EDUCA	TION	16a. DECEDEN	T'S HELIAL (COLIBATIO	A1		Les vivo es eve		100	Diack	
(Specify only highest grade co	ompleted)	(Give kind	d of work done OT use retired.	during mos	t of working		16b. KIND OF BUS	INESS/IN	DUSTRY		
12	College (1-4 or 5+) 4	Bud	get A	nalys	t		U.S. C	Gover	nment		
17. FATHER'S NAME (First, Middle, Last)					18, MOTHE	R'S NA	ME (First, Middle, Maiden	Surname)			
Albert Bu	rns						Emma Jor	ies			
19a. INFORMANT'S NAME (Type/Print)		1					Route Number, City or Yown				
Sidney H. Walker						Нуа	ttsville,		_		
26a. METHOD OF DISPOSITION 1 XBurial 2 Cremetion 3 Remove 4 Donation 5 Other (Special)	al from State	b. PLACE AND DA metery, crematory t. Linc	ATEOF DISPO or other place COLN (emet	na of e r y	11/	20121		city or Town	Maryland	
21. SIGNATURE OF FUNDALL SERVICE DICEN	WHEE E	/	22	MCG11	D ADDRESS	OF FA					
Marced		eelh	5 7	400 (Georg	ia	Ave., N.W.,	Wash	.,D.C.	20012	
23. PART I Enter the diseases, or con shock, or heart failure. Lie	mplications that cause at only one cause on o	d the death. I	Do not ente	r the mod	de of dying	g, sucl	h aa cardiac or reapi	ratory an	reat,	Approximate Interval Between	
IMMEDIATE CAUSE (Final	^			Λ.		,				Onset and Death	
disease or condition resulting in death)	Caudio DUE TO (OR AS	pulmar	rary	It	then	+					
_	DUE TO (OR AS	4 CONSEQUENC	E OF): \			,	0				
Sequentially list conditions, b.	Metas(nhe C	aru	non	rac =	7	Panere ni pour	as			
If any, leading to immediate cause. Enter UNDERLYING	5-10	·	00	. 1	21/11						
CAUSE (Disease or injury that initiated events	DUE TO (OR AS	> CONSEQUENC	E OFI:	ne	- Ju	une	M INCH V	nor	19	<u> </u>	
reaulting in death) LAST	Azutes	A	nami	a							
		7								+	
PART II. Other algnificant conditions		out not reaulti	ng in the u	nderlying	cause giv	ven In	Part I. 24s. WAS AN PERFOR		AV	REAUTOPSY FINDINGS	
ve	hydrahen						1 🗆 YES 2,	NO		OMPLETION OF CAUSE F DEATH?	
									1	YES 2 NO	
DID TOBACCO USE CONTRI	BUTE TO CAUSE C				UNCE	RTAIN	1 🗆 📗				
	HOSPITAL:	26. PLACE OF I	OTHE								
1 YES 2 NO 1	Inpatient 2 ER/Out		A 4 I Nu	rsing Home		dence	6 Other (Specify)				
27. MAINTEN OF DEATH	26a. DATE OF INJURY	28b.	TIME OF	28c. INJU	RY AT		26d. DESCRIBE HOW IN	JURY OC	CURED		

HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	□ DOA	OTHE 4 No	R: Irsing Home	5 Realdence	6 Other (Specia
26a. DATE OF INJURY	28b. TIN	E OF	28c. INJUI		26d. DESCRIBE

1 Natural
2 Accident
3 Suicide 1 YES 2 NO 28a. PLACE OF INJURY — At home, term, atreat, factory, office building, atc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e CERTIFIER	
TOU. OCT.	1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
	A and doe to the cause(s) and manner as stated.
one)	a C arrests guarantee & S. S. S. S. S. S. S. S. S. S. S. S. S.
	2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the opinion.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER

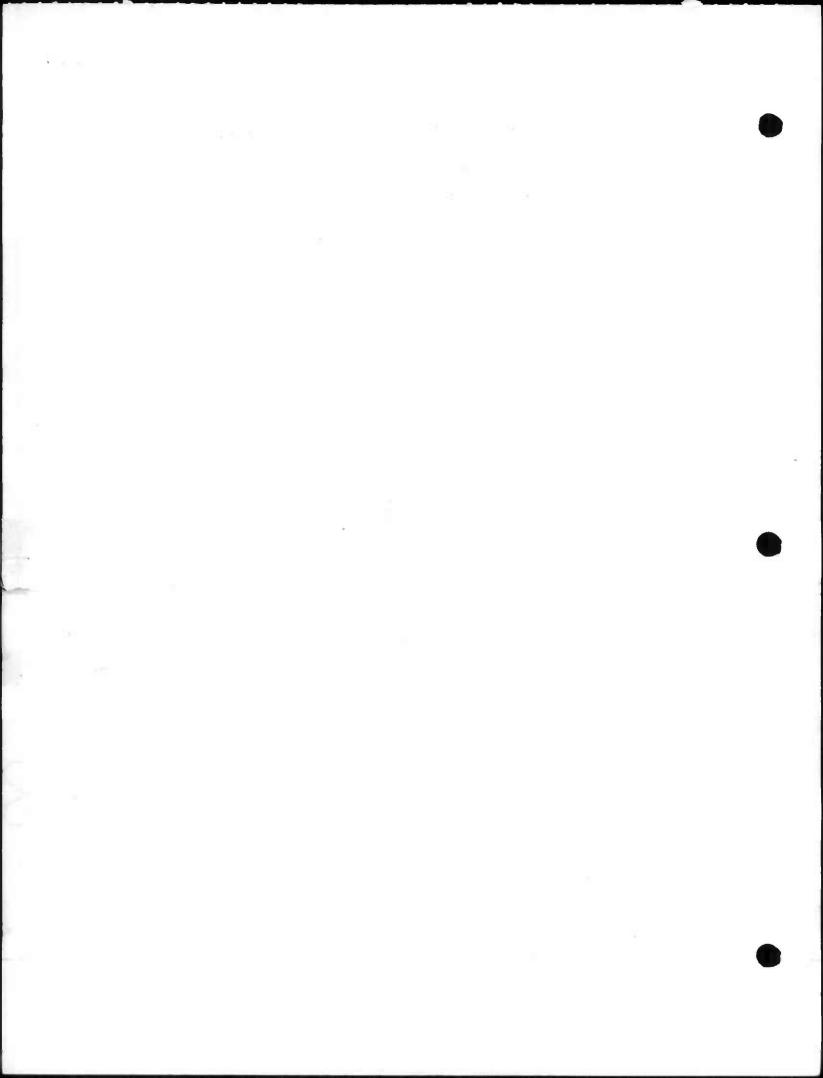
	V 6	D	av							
30. NAME AND	ODRESS	OF PE	RSON WHO	COMPL	ETED CALL	SE OF	SEATH (IT	EM 2D	/Tena	Christi

VIVER 3311 Void m.D Talualo Hy all sville Terrace

31. DATE FILES (MANY) DOX

29d. DATE SIGNED (Month, Day, Year)

25/94

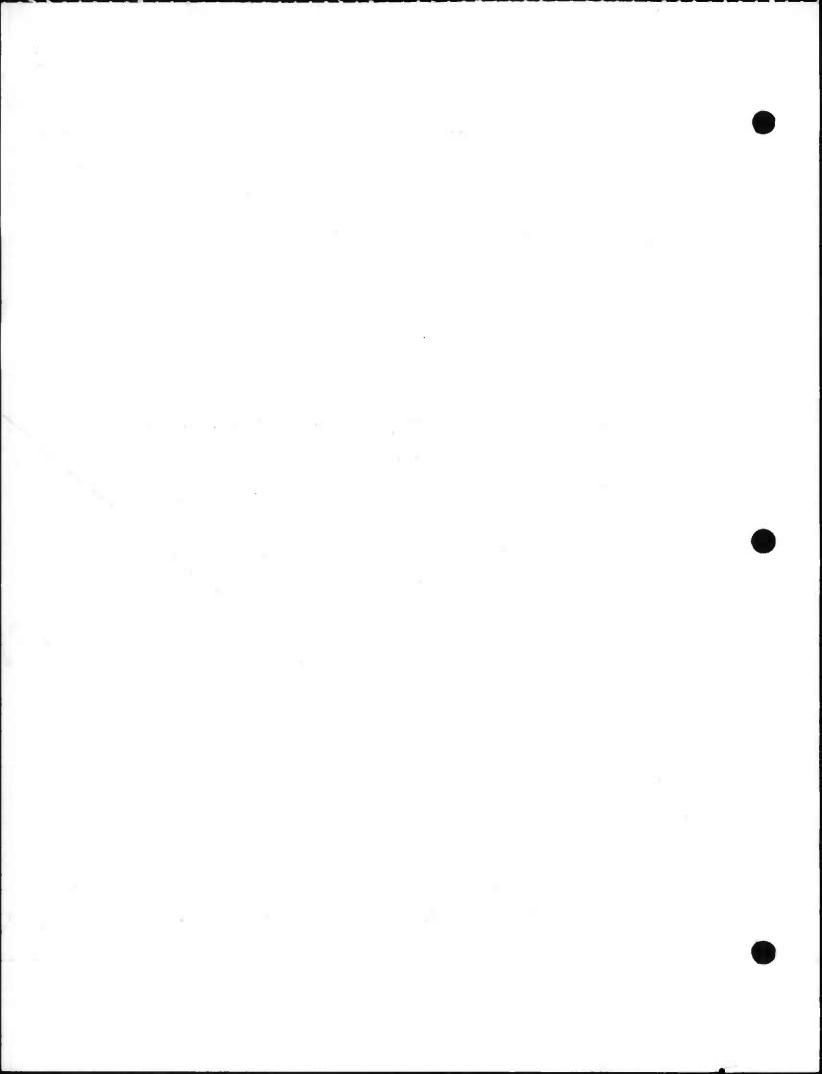


BALTIMORE, MARYLAND 21215-0020	death. Page 6 may be retained by the hospital or attending physician,	e funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should II.	examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL DR ATTENDING PHYSICIANS: The law requires that the death certificate be executed within clours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH												
	KETTH	LY	LE	WIGGINS					NOV		-	994	9:35a M
	4. SOCIAL SECURITY NUMBER	R	5. SEX	6. AGE (In yrs. le:	st birthday)	IF UNDER I	YEAR	IF UNDER 24 HRS. HOURS MIN.		OF BIRTH		8. BIRTI	HPLACE (State or Foreign
	577-94-5463	3	1 XM 2 F	32	YRS.	WONTHS	EMIS	HOURS MIN.		2, 19	962		Ö. C.
~	9a. FACILITY NAME (If not ins.	titution, give st	reet and number)			9b. CITY,	TOWN	OR LOCATION OF E	HTASO		9c. COU	NTY OF D	DEATH
0	916 Balboa	Avenu	e			(Cap:	<u>ital Hei</u>	ghts		Pri	nce	Georges
EC	10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN OF	LOCAT	TION					10d. INSIDE CITY
DIRECTOR	Md.	Pr	ince Goe	raes		Capital Heights							LIMITS?
AL	10e. STREET AND NUMBER	1,17	Ince coe	1400		- Cu		f. ZIP CODE	0.5		10g. CIT	IZEN OF V	WHAT COUNTRY?
FUNERAL	326 Possum C	Court						20743			Ur	nited	States
5	11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S. AF	MED	13. W	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- if yea, specify Cuban, Maxican, Puerto Rican, etc.)					14. RAC	E — American Indian,
ВУ	1 Never Married 2 R	Aarried	IF YES, GIVE V	MAR OR DATES	NO		If yea, specify Cuban, Maxican, Puerto Rican, etc.) □ YES 2 XNO Specify: Black Specify: Black					A	
		DENT'S EDUC	CATION	T 40. 00									Diack
	(Specify only	highest grade	completed)	(G	16a. DECEGENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) 16b. KINO OF BUSINESS/INOUSTRY								
COMPLETED	Elementary/Secondary (0-1	12)	College (1-4 or 5	"			mei	rator					
S S	17. FATHER'S NAME (First, Mid	Idle, Last)						18. MOTHER'S N.	AME (First, A	fiddle, Maiden	Sumame)		
BEC	Floyd Wi	agins								stine		5	
면 인	19a. INFORMANT'S NAME (7)7	7		19	b. MAILING	ADDRESS	(Street a	and Number or Rural					
۲	Christine	Wiggir	ns	9	16 Ba	alboa	Av	e. Capi	ital 1	Height	s. M	d. 2	0743
	20a. METHOD OF DISPOSITIO		oval from Stata	20b. PLACE	ANDDATEC	F DISPOSIT			DATI		CATION —		
	4 Donation 5 Other (Specify)				1emor		Park	bul	4 La	ndov	er,	Md.
	21. SIGNATURE OF FUNERAL					22. N	AME AI	 Horton 	ACILITY	Mortic	rians	z. Tr	nC .
	A	2.	Avotor					Kennedy				, II	10.
	23. PART I. Enter the dis	easea, or c	omplications the	t caused the de	ath. Do n							reat,	Approximata
	IMMEDIATE CAUSE (Fina		let only one cau	ise on aach iine	3.								Interval Between Onset and Death
ļ	disease or condition resulting in death)	→ ,	Acqui	ced Immu	nodef	icie	ncv	Syndron	ne (A	IDS)			one year
			DUE TO	(OR AS A CONSE	QUENCE OF):		7	, , , , ,	7			Jane Jean
8	DIE TO (OR AS \$ CONSECUTIVES OF)											one year	
E	if any, leading to immedicause. Enter UNDERLYIN	IG	DOE 10	ION AS A CONSE	JUENCE OF	<i>y.</i>							
Ĕ	CAUSE (Disease or injury that initiated events		OUE TO	(OR AS A CONSE	DUENCE OF):							
CERTIFICATION	reaulting in death) LAST		l										
- 11	PART ii. Other significan	t condition:	contribution to	death but not a	andelma I		is also to		D. a. I			1	
CAL		COMMINION	- contributing to	death but not i	eauting (ii the und	eriying	g cause given in	Part I.	24a. WAS AN / PERFORI		246	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
										1 YES 2	□ NO		OF DEATH?
Σ	DID TORACCO US	E CONT	DIDLITE TO CA	LICE OF DEA	TLI VE	c 🖂	0 -	1 ukiessa					1 Nes 2 No
BY PHYSICIAN:	DID TOBACCO US 25. WAS CASE REFERRED TO		IDUIE IU CA		E OF DEAT			UNCERIAL	ΝЦ				
SIC	EXAMINER? 1 YES 2 NO		HOSPITAL:			OTHER:		e 5 X Rasidence	4 T Ath	(Constitute			
È	27. MANNER OF DEATH		28a. DATE OF	INJURY	28b. TiME	OF 2	8c. INJ	URY AT		CRIBE HOW IN	JURY OC	CUREO	
-	t X Natural 5 Pr	ending vestigation	(Month, D	ery, rour)	INJU	M		RK? /ES 2 NO					
	3 Suicide 8 C	ould not be	28a. PLACE O	F INJURY — At ho atc. (Specify)	me, ferm, s	treet, factor	y, office	•	281, LOCA	ATION (Street as	nd Number	or Rural F	Route Number,
COMPLETED	4 Homicide de	starmined							Say C	r lown, state)			
2 1	29a. CERTIFIER (Check only	YING PHYSIC	CIAN: To the best of	my knowledge, da	ath occurre	d at the tim	e, deta	and place, and due	e to the cau	ee(a) and men	ner ea atal	led.	
S	one) 2 MEOIC	AL EXAMINER	: On the beals of e	xamination and/or	investigation	n, In my opi	inlon, d	eath occured at the	time, deta	and place, end	due to th	na cause(s) and manner as stated.
11	296. SIGNATURE AND TITLE C	F CERTIFIER						29c. LICENSE NU		Т	29d. DAT	E SJGNED	(Month, Day, Year)
O BE	Gre	-A (ulle					740-	216		> //	/22	194
=	30. NAME AND ADORESS OF I										7		
	Dennis Cui	Llen,	M.D. 510	3 Marlb	oro F	ike,	Ca	pital He	eights	Md.	2078	34	
	31. DATE FILEN TO THE DE	9 1994	32. BEGISTRA	Day don-A	and po								
- 4		-50	0	30,00,00		-							



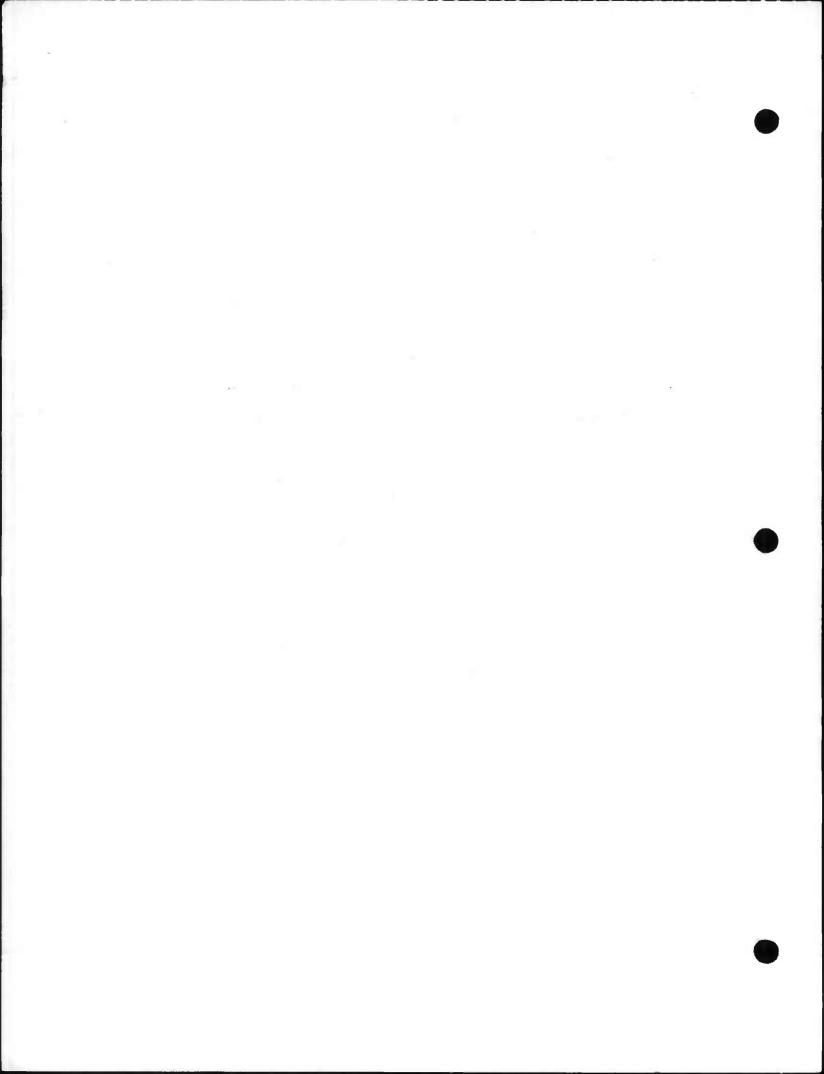
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit pe filed within 72 hours after death with the State Deat, of Health and Mental Hydiene prior to bunial, cremation, or removal.	IMPORTANT If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical assuring the medical assuring the next the medical assuring the next the next the next the next time.
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Pages 1, 2, 3 should

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH В. 26 1994 8:40 AM Nov. 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Month, Day, Yes 1 🗆 M 2 🐺 DAYS HOURS 579 38 1906 ຶ່1929 YRS Washington D.C. Se. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Anne Arundel Medical Center DIRECTOR Annapolis Anne Arundel RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Anne Arundel Crofton 1 YES ZXXNO 10e. STREET AND NUMBER FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1597 Eton Way 21114 United States 11 MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuben, Mexican. Pr Specify: White 1 YES 2X NO ВУ Specify 3 🗌 Widowed 4 📗 Divorced No 18a. DECEDENT'S USUAL OCCUPATION

(Glass kind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) 12 Supervisor Dept. of Social Service 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname) Francis J. Brown Ethel Green 田田 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Don Wheatley 1597 Eton Way Crofton Maryland 21114 20e. METHOD OF DISPOSITION
1 ☒ Burlel 2 ☐ Cremetion 3 ☐ Removal from State 20b. PLACE AND OATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE Maryland Veterans Cemetery 4 Donetion 5 Other (Specify) Crownsville, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Robert Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715 23. PART I. Entar tha disesses, or complications that caused tha death. Do not antar the mode of dying, such as cardiac or reapiratory strest, shock, or haart fallura. List only one cause on each line Interval Between **IMMEDIATE CAUSE (Final Onset and Death** Pulmonavy emboli disease or condition (mos. reaulting in death) OUE TO (OR AS A CONSEQUENCE OF) 2/2 4/5 savcoma CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) If sny, laading to immediata cause. Entar UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated evants reaulting in dasth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🗵 **PHYSICIAN:** UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one HOSPITAL: OTHER: 1 YES 2 NO Impatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Reeldence 8 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 1 YES 2 NO BΥ investigation 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State) 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the besie of examination end/or investigation, in my opinion, desth occured at the time, date end place, and due to the cause(e) and menner se stated. 296 SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. OATE SIGNED (Month, Day, Year) 出 Solonelly, un 19838 11/26 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stuaut HUNAPOLIS Uld. 21401 Selonian 900 Bestaate Kd. NOV 2 9 32. MEGISTRATI'S SIGNATURE TONGLE



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BALTIMORE, MARYLAND 2121	retained
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DS, P.O. BOX 68760	the death certificate be executed will
CORDS, P.O. BOX 68760	res that the death certificate be executed will

15-0020 DIVISION OF VITAL REC

	1. DECEDENT'S NAME (Fin		. white						DATE OF DEATH WONTH	DAY 28,	YEAR 1994	3. TIME OF DEATH
	4. SOCIAL SECURITY NUM 578-20-738		5. SEX		s. lest birthdey)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HR	s. 7.	Month () ay 1 ()	<i>5</i> -0 ₁	8. BIRTI	NPLACE (State or Fore
OR	9a. FACILITY NAME (# not Washingtor	institution, give s n Adven	street and number)	pital			or Location o	F DEATN			UNTY OF C	DEATN
DIRECTOR	RESIDENCE OF DE	10b. COUNT	Υ		10c. CI	ry, town on loca	TION		-			10d. INSIDE CITY
	D. C.	R	N/A		N	Washington 1.01. ZIP CODE 10g. CITIZEN OF WHAT CO						1 KYES 2 1
F		neridan				20011 IISA						SA
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE				NO	It yes, s	CENDENT OF NES	xicen, Pu	RIGIN? (Specify Y serto Rican, etc.)	ea or No-		E — American Indian k, White, etc. effy: .ack
TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)			164	(Give kind of	USUAL OCCUPATI work done during m	ION ost of working		16b. KIND OF B	USINESS/IN		
COMPLET	Elementary/Secondary 12th	Min Do MOT use million)					Self	-empl	oyed			
BE CO	17. FATHER'S NAME (Flist, Richard	Poin	dexter				18. MOTHER'S		First, Middle, Malde Poi	ndext	er ((Ellis)
5	190. INFORMANT'S NAME Roland Wh			100		heridan						20011
	20a. METHOD OF DISPOSE		noval from State	20b. PL/	ACE AND DATE	OF DISPOSITION (N	lame of			OCATION -		20011 own, State
	4 Donatton 5 Oth	er (Specify)	nge Co	unty Cen			2-3	Lahor	e,	Va.		
	21. SIGNATURE OF FUNER	TAL SERVICE LI	CENSEE			22. NAME A	ND ADDRESS OF	FACILIT	Marshal	1 e E	uner	al Homo
	IMMEDIATE CAUSE (F	diseasea, or heart fellure.	complications that	it coused the	line.	not enter the me	ode of dying,	uch as	Washing cardiac or rea	ton.	DC	20011 Approxima
RTIFICATION	ahock, or	diseases, or heart feilure.	a. OUE TO	at coused the	line.	Cervi	ode of dying,	uch as	Washing cardiac or rea	ton.	DC	20011 Approxima
DICAL CERTIFICATION	shock, or IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERL' CAUSE (Disease or in that initiated events	diseases, or heart feilure.	a. OUE TO DUE TO d. DUE TO	at ceused this use on each of the course of	NSEQUENCE C	OF):	cal	Car	Washing cardiac or real	piratory au	DC rrest,	20011 Approximatinterval Be Onset and Onset an
MEDICAL	shock, or IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond if any, leading to imm ceuse. Enter UNDERL' CAUSE (Disease or in that initiated events resulting in deeth) LA	diseases, or heart feilure.	a. DUE TO d. DUE TO HOSPITAL:	to ceused thise on each (OR AS A CO) (OR AS A CO) (OR AS A CO) (OR AS A CO) (OR AS A CO)	Ine. SEQUENCE CONSEQUENCE CON	In the underlying 28. P	cal	In Pari	Washing cardiac or real cardia	piratory au	DC rrest,	Approximatinterval Bei Onset and Ons
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D BY PHYSICIAN: MEDICAL	Shock, or IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond if any, leading to imm ceuse. Enter UNDERL CAUSE (Disease or in that initiated events resulting in death) LA PART II. Other algnific 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF/DEATH 1 Natural 5 Accident 3 Suicide 8	diseases, or heart feiture. Final Illitions, lediete Ying Jury In Medical To Medical Pending Investigation Could not be	a. DUE TO b. DUE TO d. DUE TO d. PLACE OF (Month, E. 28e. PLACE OF 28	to coused thise on each to contact the country of t	INSEQUENCE CONSEQUENCE CONSEQU	In the underlyle	call Ig ceuse given LACE OF DEATH THE 5 Resider JURY AT ORK? YES 2 NO	In Paris	Washing cardiac or rea 1. 24a. WAS A PERF 1 YES	n Autopsy DRMED? 2 NO	24t	20011 Approximatinterval Bet Onset and Onset a
ED BY PHYSICIAN: MEDICAL	Shock, or IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond if any, leading to imm ceuse. Enter UNDERL CAUSE (Disease or in that initiated events resulting in deeth) LA PART II. Other algnific 25. WAS CASE REFERRED EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Accident 3 Suicide 8 4 Homicide 29e. CERTIFIER (Check only)	diseases, or heart feiture. Final littons, teditete yilling littons and the condition of t	a. OUE TO b. DUE TO c. DUE TO d	t ceused thise on each (OR AS A CO) (OR AS A	Ine. OTHER NSEQUENCE C NSEQUENCE C NSEQUENCE C NSEQUENCE C NSEQUENCE C NSEQUENCE C NSEQUENCE C	In the underlying the factory, officed at the time, dat	rig ceuse given	In Pari	Washing cardiac or rea 24a. WAS A PERF 1 YES Other (Specify) D. OESCRIBE HOW City or Town, State The cause(a) and me	IN AUTOPSY ORMED? 2 NO	24k	Approximatinterval Be Onset and Onse
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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS. P.O. BOX 68760.

, hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should th the State Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.	e medical examiner must be notified at once.
IN THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FLINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 bit mad within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE

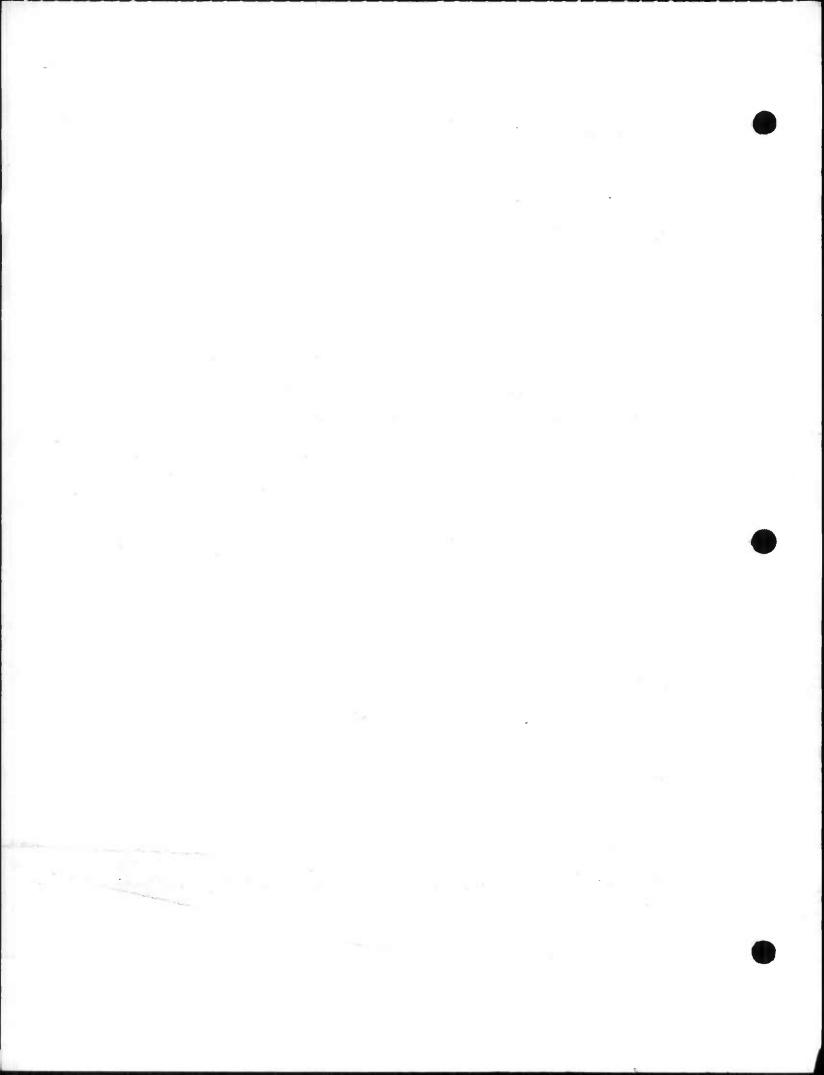
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR			ERIIF	ICALE	Ur	DEAL	I H	F	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last						2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH							
		inson H	arvey	Wat					November 25, 1994 1:10					
	4. SOCIAL SECURITY NUMBER 231-92-5450 -225-09-0096-	6. AGE (in yrs. i	iest birthday) YRS.	IF UNDER	DAY8	HOURS MIN (Mon			Month, Day, Year)			8. BIRTHPLACE (State or Foreign Country) Portsmouth, Virginia		
	9e. FACILITY NAME (If not institution, give	street end number)			9b. CITY,	, TOWN C	R LOCATIO	ON OF DE		,		INTY OF DE		
8	12816 Staton Court				Uppe	er Ma	rlbor	0			Princ	ce Geor	rae ^t s	
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUN	TV												
E		e George's C			Y, TOWN O								10d. INSIDE CITY LIMITS?	
	10e. STREET AND NUMBER	e deorge's C	ounty	Орре	er Mar		O ZIP COO	-					1XX YES 2 NO	
FUNERAL DIRECTOR	12816 Staton Court					101	2077						HAT COUNTRY?	
3	11. MARITAL STATUS	12. WAS DECEDENT	EVER IN U.S. A	ARMED	13. 1	WAS OFC			C ORIGIN? (S	nacify Yes			ates of America	
	1 Never Married 2 Merried	FORCES? 1 IF YES, GIVE W		NO	1	If yes, spi	cify Cube		, Puerto Rica		01110	Black, Specifi	— American Indian, White, etc.	
В	3 (X)(Widowed 4 Divorced						- X	ороску.					lack	
COMPLETED	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)		DECEDENT'S	vork done o	CCUPATIO	N st of workin	ig.	16b. KIN	ID OF BUS	SINESS/IN	DUSTRY		
Ä	Elementary/Secondary (0-12)	College (1-4 or 5+) "	Domest	e retired.)				П.	ome				
M	17. FATHER'S NAME (First, Middle, Last)			Domest	10									
	John Vinson							cca Ja	NE (First, Middl	le, Maiden	Surneme)			
H	19a. INFORMANT'S NAME (Type/Print)			19h. MAILING	ADDRESS	(Street a		_	oute Number, (The or Torre	o Clata 7	in Code)		
2	Joan H. Shaw								arlboro					
	20e. METHOD OF DISPOSITION			EANDDATE	_				DATE	20c. LO	CATION -	City or Tow	rn, State	
	1 X Buriel 2 Cremetion 3 Red 4 Donation 6 Other (Specify)	moval from State	Linco	n Memo	nial	Ceme	tery		11629	Port	smouth	n. Vir	ginia	
	21. SIGNATURE OF FUNERAL SERVICE L	ICENSEE #M006	90		22.1	NAME AN	D ADDRES	SS OF FAC	ILITY	11/29 1994 Portsmouth, Virginia unv ome, Inc.				
	Dourand	K/Cars	can.						31vd., 1		nouth	. VA		
	23. PART I. Entar the diseases, or	complications thet	caused tha	death. Do r									Approximate	
	ahock, or haert fellure IMMEDIATE CAUSE (Finel	. List only one caus	se on each lir	ne.									Intarval Between Onset and Death	
Ì	diseese or condition reaulting in deeth)	Metast	atre (Colm	Co	uce	2						6 weeks	
		DUE TO	OR AS A CONS											
NO.	Sequentielly list conditions,	b												
ĀŢ	If any, leeding to immediate cause. Enter UNDERLYING	00E 10 (OR AS A CONS	EQUENCE OF	-):							i l		
CERTIFICATION	CAUSE (Disease or Injury that initiated events	c. DUE TO (OR AS A CONS	EQUENCE OF	7):								İ	
	reaulting in deeth) LAST	d												
	PART ii Other significent condition	ne contributing to	death but not	requising i	n the res	el a el a el e		desar de C	Sant La					
EDICAL	_	ot resulting in the underlying ceuse given in Part i					78FT 1. 244	PERFOR	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE					
	- Charles	Sear F	decire						- 110	YES 2	₩ NO		OF DEATH?	
Σ	DID TOBACCO USE CON	TDIRLITE TO CAL	ISE OF DE	ATLL VE	c \square h	10 F	LINIC	FOTAIN					1 YE\$ 2 NO	
A	25. WAS CASE REFERRED TO MEDICAL	TRIBUTE TO CAL		ACE OF DEAT	_		UNC	EKIAIN			_			
SIC	EXAMINER? 1 YES 2 X NO	HOSPITAL:			OTHER	3:	. с ГУр.	eldenne f	Other (Sc					
PHYSICIAN:	27. MANNER OF DEATH	26e. DATE OF	INJURY	28b. TIM	E OF	28c. INJI	JRY AT		26d. OEŞCRI		NJURY OC	CUREO		
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Da	y, rear)	INJ	URY M		RK? 'ES 2	NO						
	3 Suicide 8 Could not be	26e. PLACE OF	INJURY — At I	home, farm, s	treet, facto	ory, office			261. LOCATIO	N (Street a	ind Numbe	r or Rural Ro	oute Number,	
COMPLETED	4 Homicide detarmined								0, 0 10					
립	(Check only	SICIAN: To the best of	my knowledge, o	death occurre	d at the ti	me, data	and place,	end due t	to the cause(e) and men	mer as sta	ited.		
Š	one) 2 MEDICAL EXAMIN	IER: On the besie of ex	emination end/o	r Investigatio	n, in my o	pinion, d	eath occur	ed at the t	lme, date end	place, en	d due to t	he cause(e)	end menner ee stated.	
BE	296. SIGNATURE AND TITLE OF CERTIFE	ER					-	NSE NUMI	BER		29d. DAT	E BIGNED	Month, Day, Year)	
2	Coop	mi	0				DI	64	10		> 1	1/28/9	i Y	
	30. NAME AND ADDRESS OF PERSON W					-1.	Mari 7							
	Gabriel Jaffee, M.D					ert,	mary I	and						
	NOV 3 0 199	32. REGISTRAF	Davidson	-Rando	ec_									

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E E B W	TIC THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Abours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMENT OF I	EALTH AND I	MENTAL HYGIEN	E						
	1. DECEDENT'S NAME (First, Middle, Last)	m E. Warri	en		2. DATE OF DEATH DANNER DAN	25,19	3. TIME OF DEATH					
	4. SOCIAL SECURITY NUMBER 578-56-6205 90. FACILITY NAME (If not institution, give at	7. DATE OF BIRTH (Month, Day, Year) 11/29/42 ATN	2 Washington, D									
TOR	Prince Georges					Р.	0.000					
DIRECTOR	MD P.	1	10c. CITY, TOWN OR LOCAL				10d. INSIDE CITY LIMITS? 1 📉 YES 2 🗍 NO					
	10e. STREET AND NUMBER			. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?					
ER/	7802 Glenarden	Parkway		20706		U.S.						
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 ☐ YES 2 ∑NO IF YES, OIVE WAR OR DATES	O If yes, s		IC ORIGIN? (Specify Yes n, Puerto Rican, etc.)		RACE — American Indian, Black, White, atc. Specify: Lack					
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +) (Giv. life.	CEDENT'S USUAL OCCUPATI we kind of work done during m Do NOT use retired.) Chi	ef of	Public	INESS/INDUS	TRY					
\$	17. FATHER'S NAME (First, Middle, Last)	<u> </u>	sumer Serv				I CILIEIT C					
	William Edward	Warren			ME (First, Middle, Meiden: Elizabe:	,	356					
8	19e. INFORMANT'S NAME (Type/Print)		. MAILING ADDRESS (Street									
2	Caryl Burns Wa	rren 78	802 Glenar	den Pkw	y. Glena:	rden,	Md.20706					
	Constitution Cons											
	21. SIONATURE OF FUNERAL SERVICE LIC	ENSEE		NO AODRESS OF FAC			Edwards					
	Danice	Zawaro.	2 3910	Silver			tland,MD.					
	marriage anna	DUE TO (ORAS A CONSEO					Approximate Interval Between Onset and Death					
CERTIFICATION	Sequentially list conditiona, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d											
PHYSICIAN: MEDICAL (PART II Other eignificant condition	a contributing to death but not re	Part I. 24s. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH?							
2	DID TOBACCO USE CONTE	RIBUTE TO CAUSE OF DEAT	TH YES WO T	UNCERTAIN			1 TYES 2 NO					
Ä	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. PLACE	E OF DEATN (Check only one)	3 011021(174)	, , ,							
SIC	1 ES 2 NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	□ DOA 4 □ Nursing Hor	e 5 🗆 Reeldence	e Other (Specify)							
PH	27. MANNER OF OEATH 1 Description of Description o	28e. DATE OF INJURY (Month, Day, Year)		URY AT	26d. DESCRIBE NOW IN	JURY OCCUP	ED					
BY												
ED	3 Suicide 8 Could not be 4 Nomicide determined	281. LOCATION (Street e City or Town, State)	(Street end Number or Rural Route Number, n, State)									
COMPLET		CIAN: To the best of my knowledge, dea R: On the basis of examination end/or in					euse(e) end menner ee stated.					
TO BE C	201. SIGNATURE AND TITLE OF CENTIFIED	Banque M	מ	29 LICENSE NUM		7.1	IGNED (Month, Day, Year)					
)	30. NAME OF ADDRESS OF PERSON WHO											
	NOV 3 0 1994	32. REDISTRAR'S SIGNATURE THE DAY OSON-V	fandell									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Thours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be adminished that the state have or Health and Marrial Horizone pricy in burial command. BALTIMORE, MARYLAND 21215-0020

FOR STATE REGIST STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1. DECEDENT'S NAME (First, A									MON		NAY .	YEAR	3. TIME OF DEATH
	MARIE WA 4. SOCIAL SECURITY NUMBE	6. AGE (In yrs.	iast birthday)	IF UNDER	R 1 YEAR	IF UNDE	R 24 HRS.	-	11/25/94 3:1					
	577-44-07!	92	92 YRS. MONTHS DAY			HOURS	MIN.	JUN	th, Day, Year)	902				
Œ	and the second			TONT					ION OF DI				UNTY OF I	
СТОВ	FORT WASH		UN HUSP	ITAL		FUI	KT. V	WASH	IING	TON		PRI	INCE	GEORGE'S
DIREC	10e. STATE	10b. COUNT	Υ		10c. CIT	Y, TOWN	OR LOCAT	TION						10d. INSIDE CITY LIMITS?
5	MARYLAND 1	PRIN	CE GEOR	GE'S		FOI	RT V	WASH	HING	TON				1 TYES 2 NO
AL	10e. STREET AND NUMBER						101	. ZIP COD	DE			10g. CI1	TIZEN OF	WHAT COUNTRY?
H	12021 LIV	INGS	TON ROA	D					207	44		100	U.	S.A.
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 M 3 Widowed 4 Divorce		12. WAS DECEDENT FORCES?	NT EVER IN U.S. I TYES 2 MAR OR DATES	ARMED NO		Il yes, sp	ecify Cub	OF HISPAI en, Mexica Specif	in, Puerto	IN? (Specify Ye Ricen, atc.)	s or No—	14. RAC Blac Spec	
ED	15 DECEI	DENT'S EDU	ICATION	160	DECEDENT'S	LIGUAL O	CCUBATIO	ON		La	b. KIND OF BL	ICHIFOC/N	OHOTON	BLACK
ETE	(Specify only in Elementary/Secondary (0-1	highest grad	e completed)		(Give kind of I	work done	durina mo	st of work	ing		O. KIND OF BU	ISINESS/IN	DUSTRY	
P	6th	(2)	College (1-4 or 5	+)	OWN	HON	ME					PF	RIVA	ጥፑ
COMPL	17. FATHER'S NAME (First, Mid	kile, Last)			Omi	1101	111	18. MOT	THER'S NA	ME (First,	Middle, Maider		V 1 V 23	111
ш	EDDIE PRI	EYER							LAU	RA	GREEN			
0	19e. INFORMANT'S NAME (Typ	oe/Print)			19b. MAILING	ADDRES	S (Street e	and Numbe	or Rural	Route Nui	mber, City or Tox	vn, Statu, Zi	(ip Code)	
5	GWENDOLYN DAY	VID (GRANDDAU	GHTER)	210 P	ANOR	AMA	DRIV	Æ, C	XON	HILL,	MARY	LANI	20745
	20e. METHOD OF DISPOSITIO		normal from Cana		CE AND DATE	OF DISPOS	SITION (No			DA	_	OCATION -		
	4 Donation 6 Other (S		TOTAL TOTAL STATE	- RIVE	CRDALE	PAR	K CR	EMAT	ORY	11/2	29/94	RIV	/ERDA	LE MARYLAN
- 14	21. SIGNATURE OF FUNERAL	SERVICE LI	CENSEE	1991		22.	NAME AF	NO ACORE	ESS OF FA	CILITY	בסאד. ש)ME		
	*rimbe	Uz.	CBU	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY J. B. JENKINS FUNERAL HOME 7474 LANDOVER RD, LANDOVER, MARYLAN										
7	23. PART I. Enter the dis- shock, or her IMMEDIATE CAUSE (Fina disease or condition resulting in death)	art fallure.	complications the List only one can a. Due to	at caused the	death. Do i	not enter	the mo	da of dy	ying, suc	ch aa ca	rdiac or reep			Approximata Interval Betwee
ICATION	shock, or her IMMEDIATE CAUSE (Fina disease or condition	ent failure.	a. DUE TO	of COR AS A CON	death. Do sine.	not enter	the mo	da of dy	ying, suc	ch aa ca	rdiac or reep			Approximata Interval Between
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TO THE FUNCIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Fours after death. Page 6 may be retained by the hospital or attending physician.

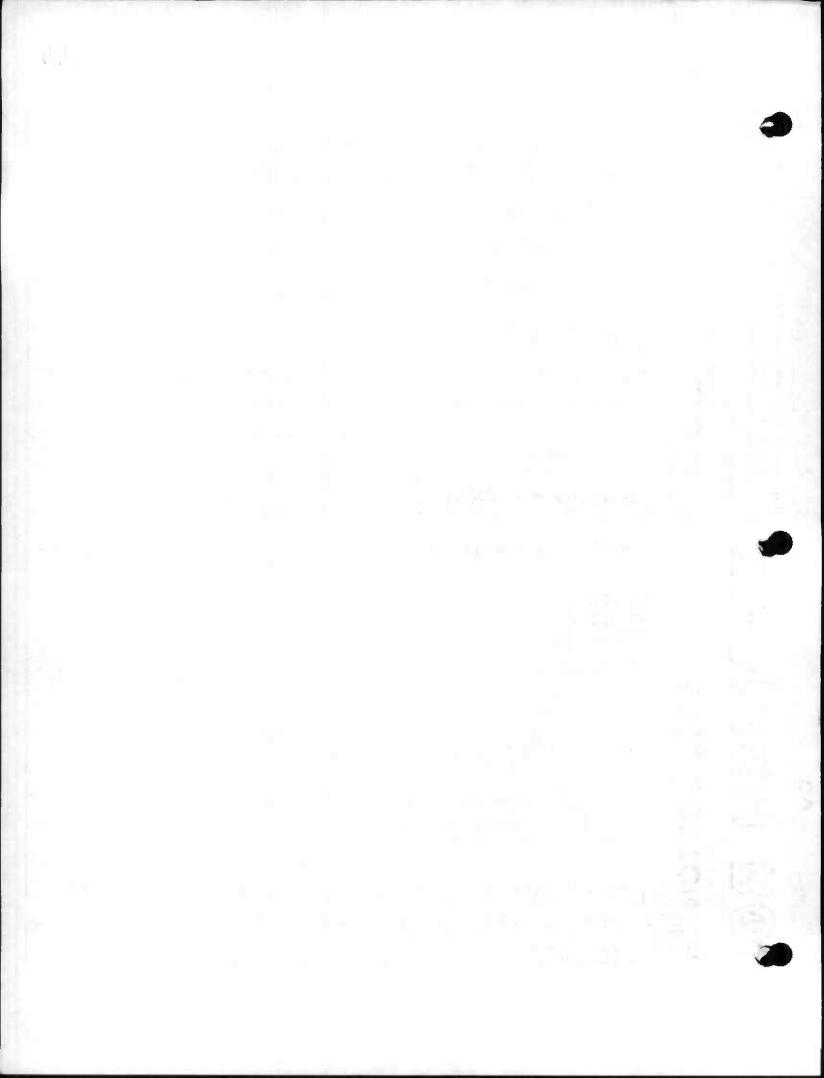
TO THE FUNCIAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merial Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,							2. DATE OF DEATH 3. TIME OF DEA								
	WILLIAM BENEDICT WOODBURN										November 26, 1994 4:00 AM					
	4. SOCIAL SECURITY NUME	5. SEX	6. AGE (in	yrs. last birthd		NOER 1 YEAR		R 24 HRS.	7. DATE OF BIRTH B.				SIRTHPLACE (State or Foreign			
	215-38-4471	1 🔀 M 2 🗌 F	64	YR	B. MONT	HS DAYS	HOURS	MIN.	Fel	b. 24,	1930	Mar	yland			
	9s. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. (CITY, TOWN	OR LOCAT	ION OF DE				JNTY OF			
E	3008 63rd A	venue				C	hever	1v				Pr	ince	George's		
DIRECTOR	RESIDENCE OF DEC															
H	10s. STATE	10b. COUNTY					VN OR LOCA	ATION						10d, INSIDE CITY LIMITS?		
	Maryland	Princ	ce George	e's	C	heve								1 X YES 2 NO		
₹ I	10e. STREET AND NUMBER						1	or. ZIP COD						WHAT COUNTRY?		
ÿ I	3008 63rd A	venue						2078	5			U.	S.A.			
FUNERAL	11. MARITAL STATUS 1 Never Married 2 🔀	Married	12. WAS DECEDED FORCES? IF YES, GIVE	X YES	2 NO		If yes, s		en, Mexica	n, Puer	IGIN? (Specify Yes rto Ricen, stc.)	or No—	14. RAC Blac Spe-	E — American Indian, ck, White, atc.		
ВУ	3 Widowed 4 Divo	rood	IF TES, GIVE	man on Dall			1 16	3 2 <u>(23</u> RO	Specify					White		
COMPLETED		EDENT'S EDU y highest grade		1	6e. DECEDEN (Give kind	T'S USUA of work di T use retin	one during n	TION nost of work	ing	- 1	Washing			rhan		
اۃ	Elementary/Secondary (6	1-12)	College (1-4 or 5	*)				Secti	on He		Sanitar					
1	17, FATHER'S NAME (First, M	(ciclin Last)			<i>t</i> uritely	III	Lance				st, Middle, Maiden			52011		
	Henry Hest		oodburn								e Hear					
BE	19a. INFORMANT'S NAME (19b. MAIL	JNG ADDI	RESS (Street		2	_	lumber, City or Tow		(ip Code)			
2	Hilda F. Wo	odbur	n		3008	63r	d Ave	enue,	Che	ver	ly, Mar	ylan	d 2	0785		
	20s. METHOD OF DISPOSIT	on 3 🗆 Rem	oval from State	20b. I	PLACE AND D	ATE OF E	DISPOSITIO her place)	N (Name	. 11	/ 20	ATE 20c. LO	CATION -	- City or 1	own, Stats		
		4 Donation 5 Other (Specify) Metropolitan Crematory 11/28/94 Alexandria, Virginia														
	111	iles		300	01	22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral H 4739 Baltimore Ave., Hyattsvill										
	23. PART I. Enter the d	Iseasea, Dr.	complications th	nt caused t	the death. I									Approximate		
	shock, Dr heert fellure. List only one ceuse on sech line.															
													6 mos			
	reaulting in dasth)		O. DUE TO	OR AS A C	ONSEQUENC	E OFI:	/							Q		
_	DUE TO (OR AS A CONSEQUENCE OF):															
CERTIFICATION	Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):															
S	If any, leading to immediate cause. Enter UNDERLYING															
E	that initiated events DUE TO (OR AS A CONSEQUENCE OF):															
ER	resulting in death) LAST															
	PART II. Other algnifica	nt condition	ns contributing to	deeth but	t not resulti	ng in th	e undariyi	ng ceuse	given in	Part I			Y 24	b. WERE AUTOPSY FINDINGS		
MEDICAL	74									PERFORMED?				AVAILABLE PRIOR TO COMPLETION DF CAUSE		
ED											1 1 123	L I NO		OF DEATH?		
														1 169 2 100		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)															
S	EXAMINER?		HOSPITAL:	□ EB/Output	Hamt 2 🗆 DC		HER:		/		Other (Specify)					
HX5	27. MANNER OF DEATH		26s, DATE O		TIME OF		NJURY AT	residence	_	DESCRIBE HOW	INJURY O	CCURED				
	1 Netural 5		INJURY	V	VORK?	□ NO	-,,,,,,		,,,,,,,,,,							
ВУ	2 Accident 3 Suicide	– At home, fa	rm, street	, factory, of			28f. LOCATION (Street and Number or Rural Route Number,									
COMPLETED	4 Homicide	Could not be determined	building	r, etc. (Specif)	y)					(City or Town, State)				
m	296. CERTIFIER															
MP	Check only One) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and dus to the cause(s) and menner as stated. MEDICAL EXAMINER: On the basis of sxamination and/or investigation, in my opinion, death occurred at the time, data and place, and dus to the cause(s) and menner as stated.															
	29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)															
BE	Surt	5	Stan	0	uno			V	182	10	7	•	. /	28/94		
5	30. NAME AND ADDRESS O	F PERSON WI	ID COMPLETED CA		TH (ITEM 27)			1		(_				
	STEPHE	EN	STAA	c lin	N 5			ors	ORA	16	E DR	. 4	-Au	DOVER WAS		
	31. DATE FILED (Month, Day,	Year)	32 REGIST	ARE AND IN	turid.						C)			- 43		
	DECO 2 1994	7 F	my kind two													



Dr #401, Rockville MO20852

Approximata Interval Between Onset and Death 18 mths

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE

8:00 P.M. M

	4	1. DECEDENT'S NAME (First, Middle, Last)		on Low	oy Woo	da		-11 F.A.	2. DATE	OF DEATH	MY	YEAR	3. TIME OF DEATH	
										8:00 P.M.				
		4. SOCIAL SECURITY NUMBER		rs. last birthday)	MONTHS	R 1 YEAR	IF UNDER 24 HRS	(Mont	OF BIRTH h, Day, Year)		Country)			
P		215 36 2796	XX M 2 D F	53	YRS.					. 19			e Md.	
2, 3 should	00	9a. FACILITY NAME (If not inetitution, give 4506 Broad Blvd.	street and number)					OR LOCATION OF	OEATH			NTY OF DE		
6,	0	RESIDENCE OF DECEDENT				ье	TUSV	TITE			Prii	ice G	eorge's	
	E C	10a. STATE 10b. COUNT	TY		10c. CI1	Y, TOWN	OR LOCA	TION					10d. INSIDE CITY	
permit. Pages 1,	DIRECTOR		ce George	e's		Belt							LIMITS? YES 2 NO	
. .	FUNERAL	4506 Broad Blvd.					10	1. ZIP CODE 2070	5				tates	
215-0020 attending physician. se as the burial-transit	BY FUI	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4XXDivorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2	E ⊠NO S	13.	If yes, sp	DECITY Cuben, Max 3 2 NO Spe	Ican, Puerto		s or No—	14. RACE - Black, Specify.	- American Indian, White, atc.	
215 aftend use as	03	15, OECEDENT'S ED		166	n. OECEDENT'S	USUAL C	OCCUPATI	ON		. KIND OF BU	ISINESS/INC	USTRY	WILLEE	
2 6 2	1	(Specify only highest grad	College (1-4 or 8	+)	(Give kind of life, Do NOT u	work done se retired.)	during m	ost of working						
	교	10			Mode1	Mak	er			Posta	1 501	rvice		
YLAND 2-by the hospital of the detached for	COMPLET	17. FATHER'S NAME (First, Middle, Last)			110.00	1101		18. MOTHER'S	NAME (First,			VICE		
7 68 %	0.1	Lawrence Willia	m Woods					Mami	e Par	doe				
MARYLAND retained by the hospit should be detached	8	19a. INFORMANT'S NAME (Type/Print)						and Number or Ru	re/ Route Num	ber, City or Tov	vn, State, Zip	Code)		
63 43	2	Stephen S. Wood	s		450	6 Br	oad	Blvd.	Belts	ville	Md.	2070	5	
m 5 g 4		20e METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Res		20b. PL	ACE AND DATE	OF DISPO	SITION (N	ame of	DAT	ATE 20c. LOCATION — City or Town, State				
ALTIMORE eath. Page 6 may funeral director, pa		4 Donation 5 Other (Specify)	cemeter Fo	y, crematory or co	COIn	Cen	netery		Brentwood Maryland					
death. Page thread directions of the death of the death.		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY												
BALT ther death. the funers oval.		Robert E. Evans Pres. Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715												
68760, executed within cours after and completely filled in by the burial, cremation, or removal ratic event the medical.		23. PART I. Enter the disease, or shock, or heart failure IMMEDIATE CAUSE (Final disease or condition resulting in death)	. METAS	STATIC	Ilne.	2 2							Approximata Interval Betwee Onset and De 18 MTh	
6 Burd and o bur	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING												
	단	CAUSE (Disease or Injury	NSEQUENCE O											
P.O. El h certifical nding phy Hygiene phy or other	Ē	that initiated events resulting in death) LAST		(0.11.00		. ,.								
DS, Porter death the attent Mental Hallery	E E		d											
ECORI quires that the n signed by f Health and	MEDIC	PART II. Other eignificent condition HYPERCAL		death but r	not resulting	in the u	nderiyin	g cause given	In Part I.	rt I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 N NO			WERE AUTOPSY FINDIN WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
	Z		_											
一戶戶意意	Ö	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHE	R:	LACE OF DEATH				_		
SICIAN: The certificate h the State h	IYS	1 TYES 2 NO	1 Inputient 2		nt 3 DOA			JURY AT	1	* * * * * * * * * * * * * * * * * * * *				
O 축 등 를	ву РН	1. Natural 5 Pending 2 Accident Investigation							28d. DE	d. DESCRIBE HOW INJURY OCCURED				
ISIC TTENDI TOR: A after de	0	3 Suictde 6 Could not be 4 Homicide determined	28a. PLACE (building,	of INJURY — i , etc. (Specify)	At home, term,	street, fac	ctory, offic	CO .		ATION (Street or Town, State		or Rural Ro	ute Number,	
対域に	3	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICAL EXAMIN	SICIAN: To the best of										and manner as stated	
THE HOSPI THE FUNER filed within	Ö										Month, Day, Year)			
THE BIRTH	BE	and In	an n		0 332		Dec 3. 1994							

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Edmonston

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

9		237-38-23	272	1 □ M 2X□XF		73	3 YAS.	MONTHS	DAYS	HOURS	MIN.	OCT.	Day, Yes 4,
3 should	nr.	96 FACILITY NAME (If not in	stitution, give s	street and number)	4.5	11 -	\	9b. CITY,	TOWN Q	R LOCATI	ON OF DE	ATH	
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	H.	10e. STATE	10b. COUNT				10c. CITY	, TOWN O	R LOCAT	ION			
permit. Pages	LDI	MARYLAND	PRIN	CE GEOR	GE'	S		OXO					
	RA	1312 DUI	MMOOD	Y AVENU	r.				101.	ZIP COD	⊑ 2074	5	
D'20 physician. burial-transit	FUNERA	11. MARITAL STATUS	WOOD	12. WAS DECEDEN		U.S. ARI	MED	13. 1	WAS OFC			IC ORIGIN?	(Specifi
P 2 2	B	1 Never Married 2 Never Marrie		FORCES? 1 IF YES, GIVE W	_ YES	2 (XN	0	1	f yes, spe	2 X NO	n, Maxican Specify.	, Puerto Ric	en, etc.
	밀		EDENT'S EDU y highest grade			(Gh	6a. DECEDENT'S USUAL OCCUPAT (Give kind of work done during n				ATION most of working		
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the hospital detached fo	COMPL	17. FATHER'S NAME (First, M	licicile, Last)			п	JUSE	WIF.	<u>-</u>	16. MOT	HER'S NAM	AF (First Mi	OWI
at of	ш	JULIUS	JONE	S							16. MOTHER'S NAME (First, Middle, MI BLANCHE T		
retained by the S should be notified at	10 B	19a. INFORMANT'S NAME (ype/Print)							eet and Number or Rural Route Number, City			; City or
	-		URNER	/ DAUGH	TER	3	3825	ST	. B	ARN	ABAS	ROA	D 5
FE CO		20a. METHOD OF DISPOSIT 1 Burlel 2 Cremetic	n 3X Rem	oval from State	20b. PLACE AND DATE OF DISPOSITION (Name of cametery, crematory or other pleca)							DATE	20c
Page 6 mil director,		4 ☐ Donetion 5 ☐ Other 21. SIGNATURE OF FUNERA		CENSEE /	- S'	r. D	ELIG	TTS (CHUR	CH C	EM.	1126	
4 8 - X		Juan	van	a.d. E	520	Wto	M		474	J.B. LAN	JE VDOV	NKIN ER R	SI
nours after d in by the or removal		23. PART I. Enter the d	iseasea, or o	complications that List only one cau	caused	tha das	th. Do n	ot antar	tha mo	da of dy	ing, auch	as cardia	ic or re
y fille		IMMEDIATE CAUSE (Fir disease or condition resulting in death)		. (0	va	e51	LIN UENCE OF	e E	ka	ext	Fa	vel.	152
certificate be executed physician and Hygiene prior to bur other traumatile	ERTIFICATION	Sequantially list condit if any, leading to imme cause. Entar UNDERLY CAUSE (Disease or inju that initiated events resulting in death) LAS	diata ING Iry	C			UENCE OF						
the death y the attend Mental Pinjury, o	L CE	PART ii. Other aignifica	nt condition	a contributing to	death b	ut not re	aulting is	n₀tha un	darlying	cause o	olvan in f	Part i. 2	4a. WAS
requires that the signed by of Health and shows any in	MEDICA	DID TOBACCO	ova	B'CECC CONTRIBUTE	af	Fa	uil	492	4.0	ole	vet g	1	PER
> 0	CIAN:	25. WAS CASE REFERRED TO		JONIKIBUTE	10	CAUS	E OF	DEAT		ES 🔲	NO	ck only one)	
N: The lav ficate has State Dep	SICI	EXAMINER?		HOSPITAL:	ER/Outo	atient 3	□ DOA	OTHER	t:	5 R			
DING PHYSICIAN After this certific death with the	РНУ	27. MANNER OF DEATH		28a. DATE OF (Month, De	INJURY		28b. TIME	OF	28c. INJI	JRY AT	reiderica	8 Other (
DING PHYS After this death with	ВУ		Pending investigation	(Monni, De	ay, roury		INOC	M		ES 2	NO		
TTEN TOR			Could not be datarmined	28a. PLACE Of building,	F INJURY atc. (Spec	— At hon	ne, ferm, s	treet, facto	ory, office	1		281. LOCAT City or	Town, S
AL DIRI	COMPLETE			CIAN: To the best of									
THE HOSPI TO THE FUNER IN filed within	BE	29b. SIGNATURE AND TITLE	OF CERTIFIE	Te	11	11/	1/1	1.		29c, LICI	34	BER 2	74
	유	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CAUS	E OF DE	ATH (ITEM	27) (Type,	Print)		4		1	-/-

94 37146 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 3. TIME OF DEATH A 2. DATE OF OEATH NOVEMBER 20 1994 6-30 7. DATE OF BIRTH
(Month, Day, Year)
OCT. 4, 1921 8. BIRTHPLACE (State or Foreign NORTH CAROLINA 9c. COUNTY OF DEATH PMINER- GRONGES 10d. INSIDE CITY LIMITS? 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA DENT OF HISPANIC ORIGIN? (Specify Yes or No— y Cuban, Maxican, Puarto Rican, atc.) X NO Specify: RACE — American Indian, Black, White, etc. Specify: BLACK 16b. KIND OF BUSINESS/INDUSTRY OWN HOME L. MOTHER'S NAME (First, Middle, Maiden Surname) BLANCHE THOMAS Number or Rural Route Number, City or Town, State, Zip Code) RNABAS ROAD SUITLAND, MARYLAND 20c. LOCATION — City or Town, State NORTH 11-26 NASH COUNTY, CAROLINA ADDRESS OF FACILITY
B. JENKINS FUNERAL HOME 20785 LANDOVER ROAD LANDOVER MARYLAND of dying, auch as cardiac or respiratory arrast, Interval Between **Onset and Death**

> 24a. WAS AN AUTOPSY PERFORMED? 1 TES 2 NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

1 | YES 2 | NO

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

28d. DESCRIBE HOW INJURY OCCURED

place, and due to the cause(a) and manner as stated. occured at the time, data and place, and due to the cause(s) and menner as stated.

c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

121.94

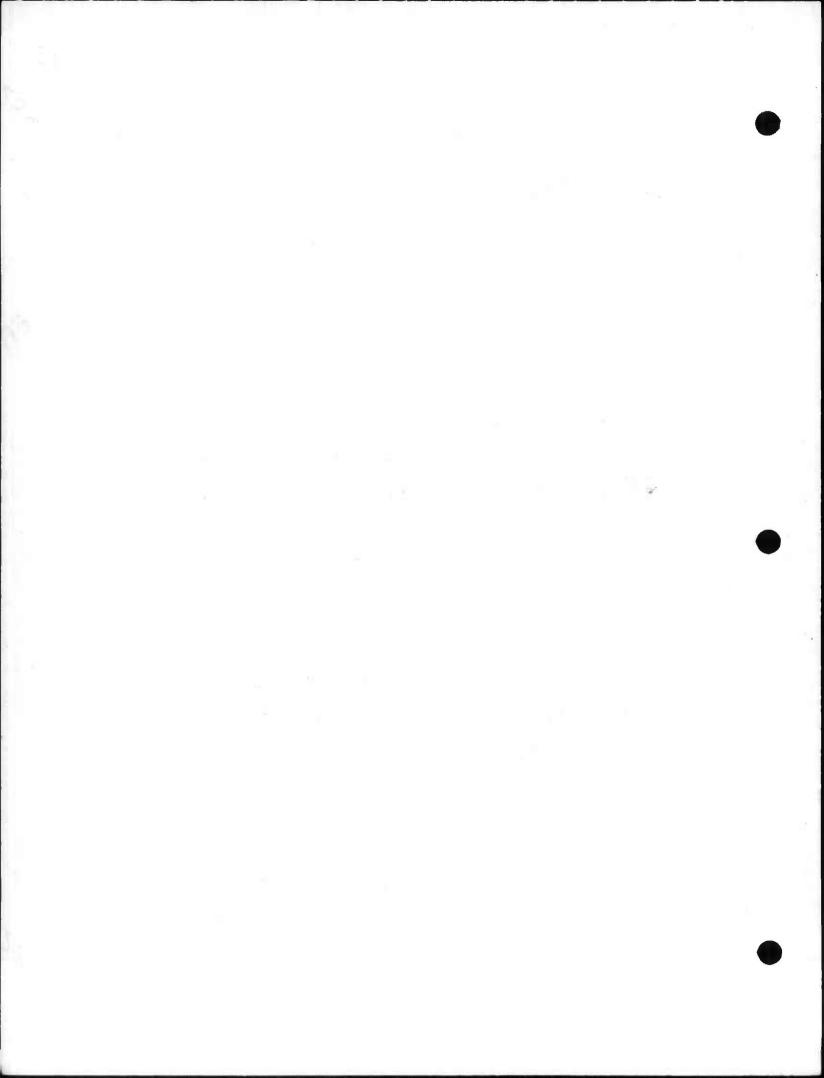
7700 OLD BRANCH 32. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

IF UNDER 24 HRS.

AGE (In yrs. last birthday) IF UNDER 1 YEAR

Lulia Davidson-Randelle



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

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31. OATE FILEO (Morith, Day, Year)
NOV 2 8 1994

22. REGISTRAR'S SIGNATURE
July Davidson Radall

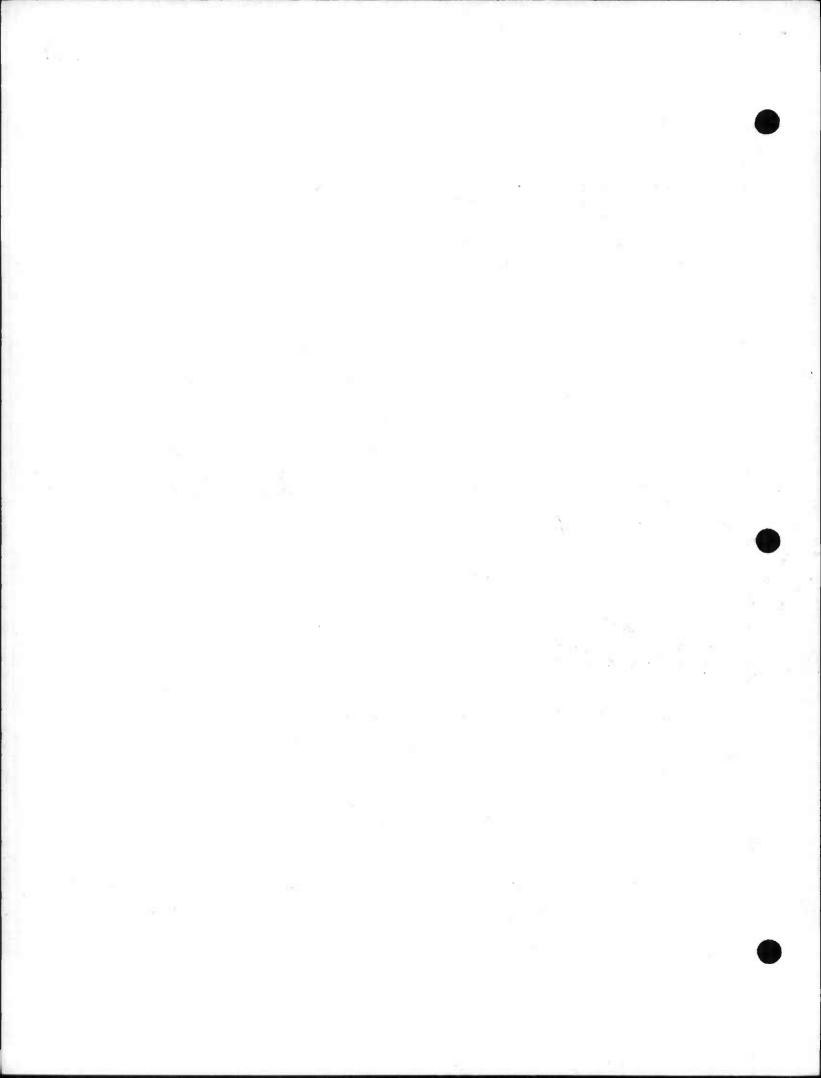
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								9	4 3	7147
	1 - STATE REGISTRAR	STATE OF M			TMENT OF		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last	,		,	ICATE OF	DEATH		DAY	YEAR 3.	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last	AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.					1954	7:45 A, M ACE (State or Foreign
	216-20-2060	1 🗆 M 2 💢 F	70	YRS.	MONTHS DAYS	HOURS MIN.	April 5,1	924	Country	enna.
N.	Sa. FACILITY NAME (If not institution, give Howard County Ge				96. CITY, TOWN Colum	OR LOCATION OF D	DEATH		Howard	
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUN	TY		10c. CIT	Y, TOWN OR LOCA	TION			d. INSIDE CITY	
	,	loward		E.	llicott	City				LIMITS?
FUNERAL	9214 Frederick Ro	ι.			.10	21042		10g. Cl	U.S.A	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1	TEVER IN U.S. ARI YES 2 J.N WAR OR DATES A	MEO IO	If yea, s		ANIC ORIGIN? (Specify Year, Puerto Rican, etc.)	14. RACE — Black, V Specify:	American Indian, White, atc.	
TED	15. DECEDENT'S ED (Specify only highest grad	UCATION de completed)	16a. DE0 (Gir	CEDENT'S	USUAL OCCUPAT work done during m se retired.)	ION ost of working	16b. KIND OF BU	JSINESS/IN	OUSTRY	
COMPLETED	Elementary/Secondary (0-12) 0-12	College (1-4 or 5 to 1 year	+)		stered N		Medi	cal		
BE CON										
TO B	19a INFORMANT'S NAME (Jona/Print)									042
	20a. METHOD OF DISPOSITION 1 Alburial 2 Cremation 3 Ramoval from State 4 Donation 6 Other (Specify) 20b. PLACE AND DATEOF DISPOSITION (Name of company, generally ge									State
										e, Mu.
	Stanley 2	1. Low	vner				mbia Pike			ity 21043
	23. PART I. Enter the diseeses, or shock, or haert fellure	complications the	t coused the deuse Dn aach lina.	eth. Do						Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in dasth) a. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): CORDIAGY ARTERY DISCERSE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
7	3	ODE TO	(OR AS A CONSEC	DUENCE O	An n	5011	1:05000			
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO	(OR AS A CONSEC	NUENCE O	F):	ny.	DISCHSE			
IFIC/	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	C. DUE TO	(OR AS A CONSEC	UENCE O	F):					
ERT	resulting in death) LAST	d								-
EDICAL C	PART II. Other significent condition	ons contributing to	death but not re	esulting	In the underlyle	ng ceuse given in	PERFO		AA CI	ERE AUTOPSY FINDINGS MILABLE PRIOR TO DMPLETION OF CAUSE F DEATH?
Σ	DID TOBACCO USE	CONTRIBUT	E TO CAUS	SE OF	DEATH	YES N	0.0		1	YES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		L TO CAU	3L ()	26. F	LACE OF DEATH (C				
HYSI	1 TES 2 NO	HOSPITAL: 1 Inpatient 2		DOA	OTHER:	me 5 Residence	6 Other (Specify)			
ву рь	1 Natural 5 Pending 2 Accident Investigation	(Month, D		26b. TIN	JURY W	ORK? YES 2 NO	28d. DEŞCRIBE HOW	INJURY O	CCURED	
ED	3 Suicide 6 Could not be determined	26a. PLACE O building,	OF INJURY — At hor etc. (Specify)	me, tarm,	street, factory, offi	COR	261. LOCATION (Street City or Town, State		er or Rural Rou	te Number,
MPLET	anal .						e time, data and place, a			nd manner on state of
E CO	29b. SIGNATURE AND TITLE OF CERTIFI		370001	gertt	,, spinioti,	29c. LICENSE NU		_		onth, Day, Year)
TO BE	Keun Co	ohe	un			V25	220	> \	(/22	197
-	30. NAME AND ADDRESS OF PERSON W	COOK		27) (Type	Print)	0 AAA ()	, C	(00		Hose. w

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BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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10 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mounts after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Day, Year)

NOV 28 1994

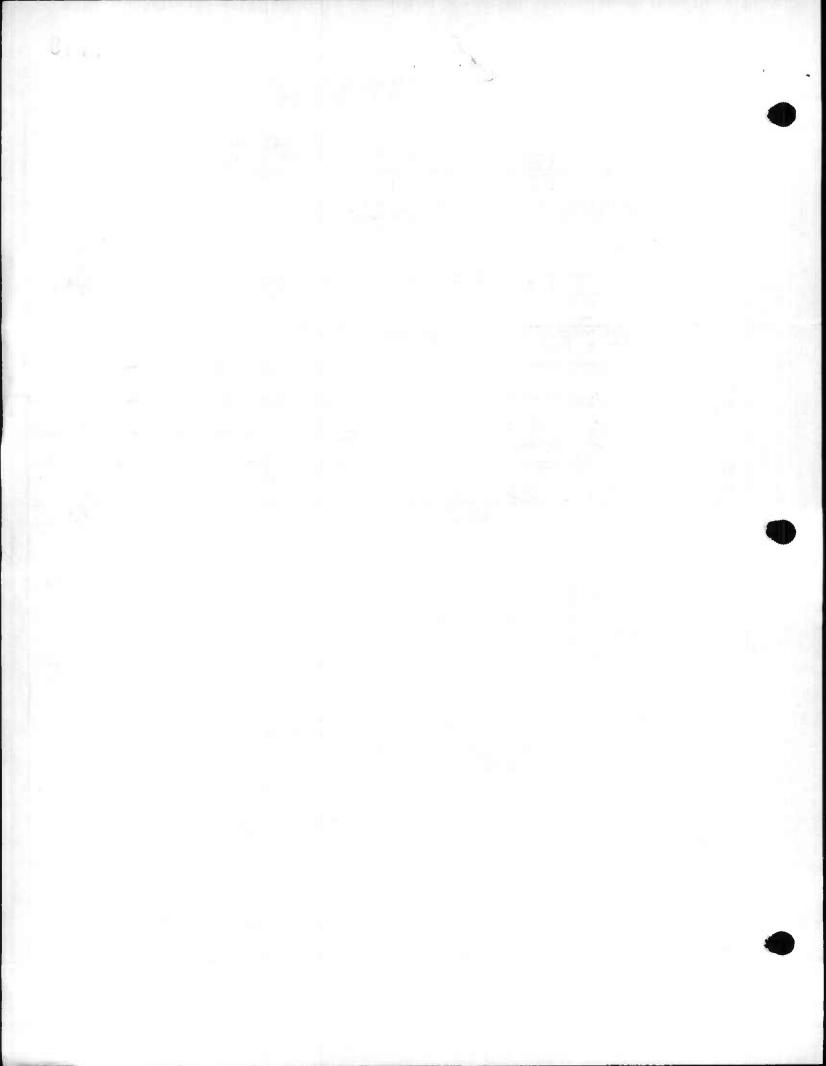
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF OEATH HTHOM Otho H. Wilkerson 1994 7:30 P w SOCIAL SECURITY NUMBER S. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Country) 02-12-1897 Maryland IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 225-48-3741 MONTHS DAYS HOURS MIN 1 X M 2 | F 97 YRS. 9s. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF OEATH DIRECTOR Hartley Hall Nursing Home Pocomoke City Worcester RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY VA. Accomack New Church 1 - YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 28244 Pitts Creek Road 23415 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: White BY 3 Wildowed 4 Divorced 18e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade complete (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 8+) 8 Farmer Produce 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surneme) William E. Wilkerson BE Mamie Taylor 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 7410 Pocomoke River Road, Pocomoke City, MD.21851 Philip R. Wilkerson, Sr. 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 1 M Buriel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) John W. tory or other place)
Taylor Memorial Cem. 11/23/94 Temperanceville 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY VA. Williams-Parksley Funeral Home 25046 Parkslev Road, Parkslev 23421 23. PARTA. Enter the diseases, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final Onset and Death arterioschrolie Heart Disease disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): breneralized CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediata ceuse, Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 KNO arthritis 1 YES 2 1 NO Bilateral PHYSICIAN: neumoura 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
4 Nursing Home 8 Residence 8 Other (Specify) 1 - YES 2 NO Nent 2 - ER/Outpetlent 3 - DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 🔀 Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be determined 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide 1 M CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner ee stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(e) end manner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month. Day. Year) 29505 11-22-94 20 5 30, MAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF CEATH (ITEM 27) (Type, Print)

REGORIO M. BELLOSO MD 4421 BEECHWOOD PL., CRISFIELD, MD 21817

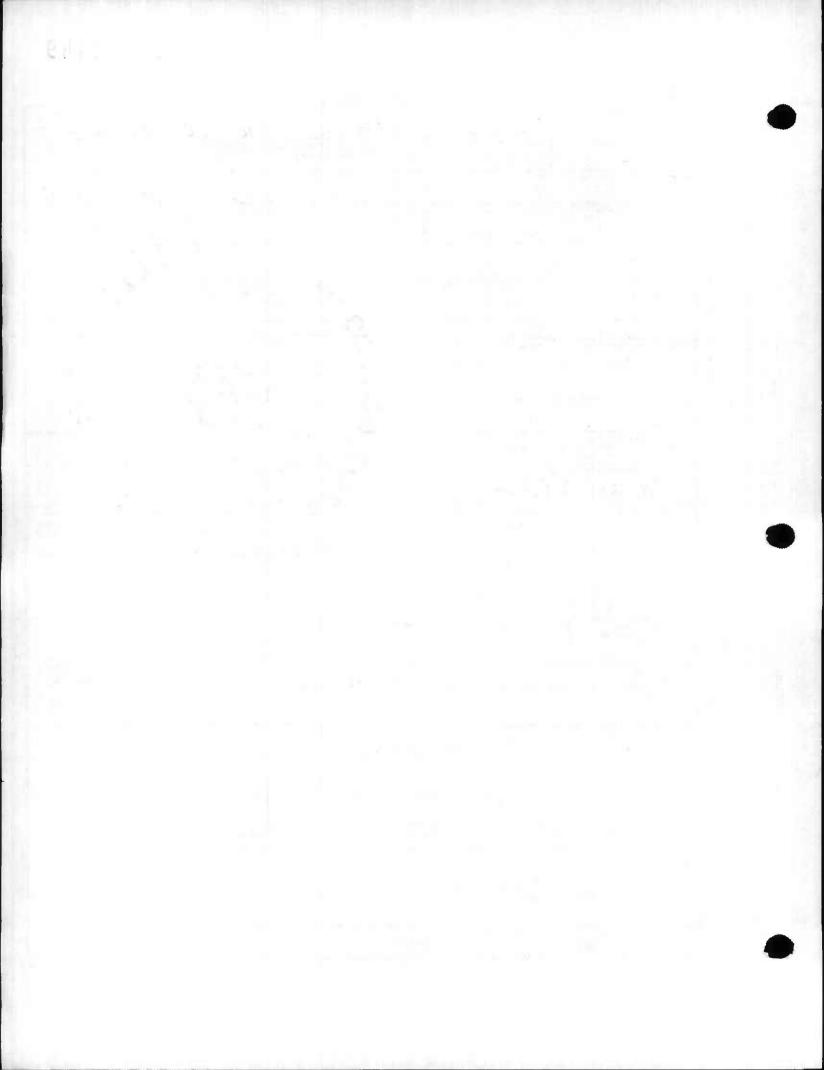
DATE FILED (MONTH, Day, 1941) 32. REGISTRAR'S SIGNATURE

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RECTOR		tolan	111	111	1:00	MONTH	OF DEATH DAY		3. TIME OF DE			
	4. SOCIAL SECURITY NUMBER	5, SEX 8, A	We	UB	1115	10	30	-	4 103			
	213-18-5637	1 M 2 F	GE (In yrs. last birthday 8 7 YRS.			IN. (Month.	DE BIRTH Day, Year)		BIRTHPLACE (State or Country)			
	9e. FACILITY NAME (If not institution, give s		0 / THS.				01/0					
DIRECTO	Mallard Bay N		m o	96. CITY,	TOWN OR LOCATION	OF DEATH		Y OF DEATH				
DIREC	RESIDENCE OF DECEDENT	dising no	III e	Cambridge Dorches								
8	10a. STATE 10b. COUNTY		10c. C	TY, TOWN OF	LOCATION				10d. INSIDE CI			
	Maryland D	orchester			Rh	odesda	le		1 YES 2			
4	10e. STREET AND NUMBER				10f. ZIP CODE			10g. CITIZE	N OF WHAT COUNTRY			
E	5529 Shar	ptown Roa	d		2	1659		Unit	ed State			
BY FL	11. MARITAL STATUS 1	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O	ES 2 NO	H	AS DECENDENT OF H yes, specify Cuben, M YES 2 NO S							
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT	S USUAL OCC	CUPATION ging most of working	16b.	KIND OF BUS	INESS/INDU	STRY			
	Elementary/Secondary (0-12)	College (1-4 or 5+)			ring most of working		Oran	Home				
₩ L	Tenth		Hoi	nemak	er		OWII	TOTHE				
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER	S NAME (First, M	liddle, Meiden S	Sumeme)				
ш	Wilson Fooks Victoria Ruark											
TO BE	19a. INFORMANT'S NAME (Type/Print)				Street and Number or F							
-	William L. Wa				green A	Ve., S	eafor	rd, D	E 19973			
	20s. METHOD OF DISPOSITION 1√2-Burlel 2 □ Cremetion 3 □ Reme	oval from State	20b. PLACE AND DATE	OF DISPOSIT	ION (Name of	DATE	20c. LOC	ATION — CI	y or Town, State			
	Commetter Comm											
	21. SIONATURE OF FUNERAL SERVICE LICENSEE PO Box 43, Federalsburg, MD 21632											
1												
RTIFICATI	Sequantially list conditions, if sny, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		AS A CONSEQUENCE (
G	PART II. Other significant condition Organic B. S.		h but not resulting Pla C V 1		Me Olile	is_	24a. WAS AN A PERFORM 1 YES 2	MED?	24b. WERE AUTOPSY AMAILABLE PRIO COMPLETION OF OF DEATH? 1 YES 2			
MEDIC	OF WAS CASE DECEMBED TO MEDICAL				26. PLACE OF DEATI	Check only one	1)					
MEDIC	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	hutantine a C ===	QTHER:				e 8 🗆 Other (Specify)				
MEDICA	EXAMINER?	1 Inputient 2 ER/C		4 Nursi		nce 8 🗆 Other						
PHYSICIAN: MEDICA	EXAMINER?		7Y 28b. TI	4 Nursi	8c. INJURY AT WORK?	nce 8 Other	(Specify)	JURY OCCU	RED			
MEDIC	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation	1 Inpatient 2 ER/C 28e. DATE OF INJUI (Month, Day, Yea	28b. Til	4 Nursir ME OF 2 JURY M	8c. INJURY AT WORK?	nce 8 Other	CRIBE HOW IN					
ED BY PHYSICIAN: MEDICA	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	1 Inpatient 2 ER/C 28e. DATE OF INJUI (Month, Day, Yea	RY 28b. Ti	4 Nursir ME OF 2 JURY M	8c. INJURY AT WORK?	28d. DESC	CRIBE HOW IN		RED Rurel Route Number,			
ETED BY PHYSICIAN: MEDIC	EXAMINER? 1 YES 2 27. MANNER OF DEATH 1 Metural 5 Pending investigation 2 Accident 8 Could not be determined	28e. DATE OF INJUI (Month, Day, Yee 28e. PLACE OF INJUI building, etc. (S	RY 28b. Till IN 18 18 18 18 18 18 18 18 18 18 18 18 18	4 Nureir ME OF JURY M street, lactor	8c. INJURY AT WORK? 1 YES 2 NO y, office	28d. DESt	TION (Street err Town, State)	nd Number or	Rural Route Number,			
COMPLETED BY PHYSICIAN: MEDICA	EXAMINER? 1 YES 2 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident a Could not be determined 29e. CERTIFIER (Check only	28e. DATE OF INJUI (Month, Day, Yes 28e. PLACE OF INJUI (Month, Day, Yes 28e. PLACE OF INJUI Duilding, etc. (S) CIAN: To the best of my kn	AY 28b. Till 18 28	4 Nureir ME OF JURY M street, lactor	8c. INJURY AT WORK? 1 YES 2 NO 1, office e, date end place, end nion, death occured a 29c. LICENSE	28d. DESt 28f. LOCA City o	TION (Street er r Town, State) De(e) end menr	nd Number or	Rural Route Number,			
O BE COMPLETED BY PHYSICIAN: MEDICA	EXAMINER? 1 YES 2 27. MANNER OF DEATH 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	28e. DATE OF INJU (Month, Dey, Yee 28e. PLACE OF INJU (Month, Dey, Yee 28e. PLACE OF INJU Duilding, etc. (S) CIAN: To the best of my kr 3: On the besie of examina	AY 28b. Till IR JRY — Al home, lerm, howledge, death occur ation end/or investigat	ME OF 2 JURY M street, lactor	8c. INJURY AT WORK? 1 YES 2 NO 1, office e, date end place, end nion, death occured a 29c. LICENSE	28d. DES(TION (Street er r Town, State) De(e) end menr	nd Number or	Rural Route Number,			



REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Nancy Lee Mitchell Williams 2:35 p. Oct. 27 1994 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year B. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1 M 2 🙀 218-48-8160 Nov. 8, 47 1946 Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR N. Maryland Ave. Ridgely Caroline RESIDENCE OF DECEDENT 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Caroline Ridgely 1 X YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101, ZIP CODE use as the burial-transit 7 N. Maryland Ave. 21660 U.S.A. retained by the hospital or attending physician 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Merried 1 YES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) page 5 should be detached for 12 cafeteria assistant Caroline County School Boar 17. FATHER'S NAME (First Middle Lest) 16. MOTHER'S NAME (First, Middle, Meiden Surname) 70 Clifton W. Mitchell Grace Sard Mitchell BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Foster Williams P.O. Box 211 Ridgely, Maryland 21660 after death. Page 6 may be Pe 20a. METHOD OF DISPOSITION

100 Burlel 2 Cremetion 3 Ref
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State funeral director, must Greensboro Cemetery 10/30 Greensboro, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Fleegle-Helfenbein Funeral Home P. O. Box 160 Greensboro, Maryland 21639 100 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. fined in by Approximata Interval Batween 0 Onset and Death IMMEDIATE CAUSE (Final the Earenma disease or condition ankunn 12 1 completely reaulting in death) event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF) burial, other traumatic CERTIFICATION attending physician and Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): 2 if any, leading to immediate cause. Enter UNDERLYING prior CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST the atten PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? any 1 TES 2 NO Health Shows 1 TYES 2 TNO has been of h PHYSICIAN: HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h OTHER:
4 □ Nursing Home 5 Residence 6 □ Other (Specify) HOSPITAL 1 TES 2 NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 28e. OATE OF INJURY (Month, Day, Year) 26d. DESCRIBE HOW INJURY OCCURED 27 MANNER OF DEATH 28c. INJURY AT WORK? marked, 1 Natural 5 Pending Investigation 1 YES 2 NO BY death DIRECTOR: After 2 Accident 3 Suicide 28s. PLACE OF INJURY — At home, farm, street, factory, office building. etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town. State) 99 6 Could not be COMPLETED hours after item 28 is 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end manner as stated TO THE HOSPITAL
TO THE FUNERAL (
Be filed within 72 h
IMPORTANT: If II (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death of 29d. DATE SIGNED (Mgnth, Day, Year)
| 10 | 31 | 94 29c. LICENSE NUMBER BE 78 D3588 2 PLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

21601

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

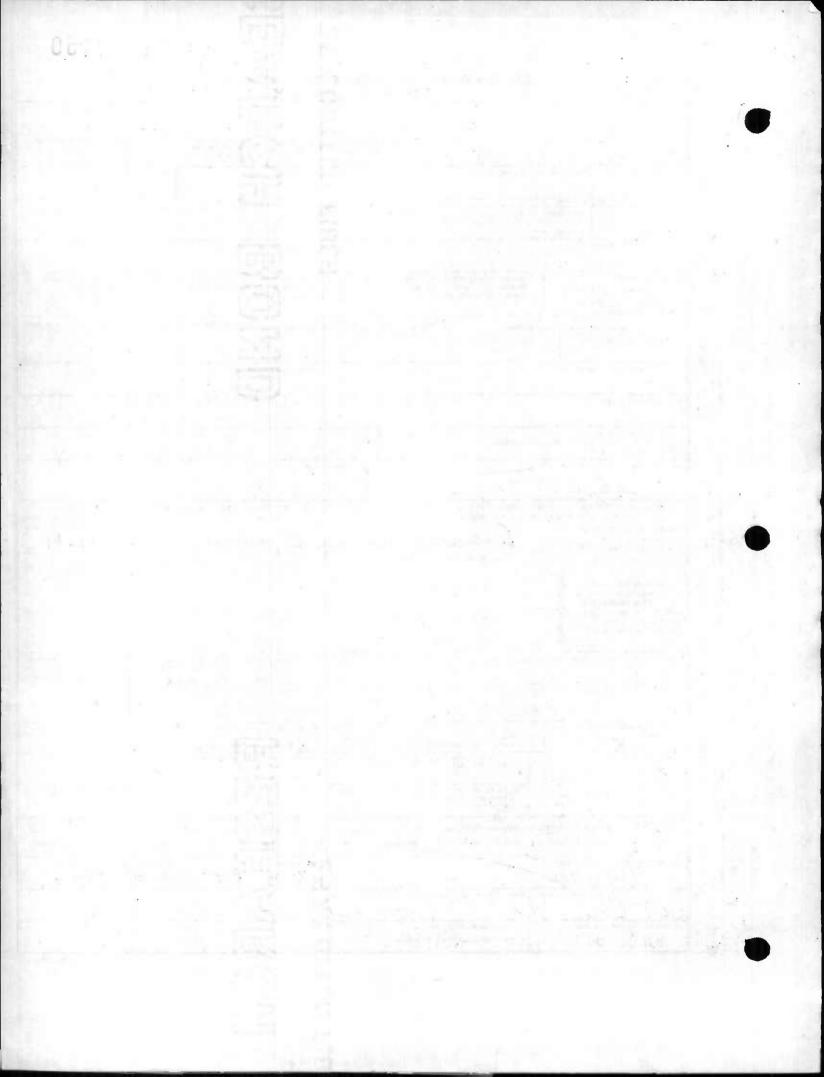
FOR STATE REGISTRAR

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32. REGISTRAR'S SIGNATURE un navidson-Mandale

31. DATE FILEO (Moi

NOV 01



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CE	HILL	ICALE	OF D	EAII	H		REG. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)	100							2. DATE O			YEAR	3. TIME OF DEATN
		Louise	Hattie V	Wright						Nov.		1994	TEAR	12:15 A M
_		4. SOCIAL SECURITY NUMBER		B. AGE (In yrs. las	t birthday)	IF UNDER 1	YEAR IF	F UNDER 24	4 HRS.	7. DATE O	F BIRTN		8. BIRTN	PLACE (State or Foreign
		216-48-5698	1 □ M 2 □ F	70	YRS.	MONTHS	DAYS H	OURS	MIN.		Day, Ybar)	024	Country	ginia
Should		9a. FACILITY NAME (If not institution, give s	street and number)			9b. CITY. T	Jan. 9,			9, 1		NTY OF D		
8	Œ													
1, 2,	6	Weslevan Health	Care Cente	er			Der	<u>iton</u>					Carol	ine
Pages 1	DIRECTO	10a. STATE 10b. COUNT			10c. CIT	Y, TOWN OR	LOCATION	Y						10d. INSIDE CITY
S.	등	Maryland	Caroline		Ridgely									LIMITS? 1 TYPES 2 NO
permit.	1	10e. STREET AND NUMBER	carorine					P CODE	у			40° OIT	175N OF W	HAT COUNTRY?
	M	106 P-11 3 1			21660									
DZU physician. burial-transit	FUNERAL	106 Railroad Ave	12. WAS DECEDENT										S.A.	
D Selection of the sele	립	1 Never Married 2 Married	YES 2 N	NO If yes, specify Cuban, Maxican,					IC ORIGIN? I, Puerto Ri	(Specify Yes ican, atc.)	or No-	14. RACE Black	— American Indian, , Whita, atc.	
or attending physician.	BY	3 Widowed 4 Divorced	IF YES, GIVE WA	R OR DATES		1 YES ZY NO Specify:							Specif	
Z15-00Z0 attending physic	ED	15. DECEDENT'S EDU	CATION	16a DE	CEDENT'S	I DOCC	LIBATION			1 405	V 05 D			casian
or att		(Specify only highest grade	completed)	(Gi	DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)					100.	KIND OF BUS	SINE 35/INI	JUSTRY	
of for	ايرا	Elementary/Secondary (0-12)	None		Homemaker						Ho	me		
AND he hospit detached	COMPL	17. FATHER'S NAME (First, Middle, Last)	110110			- Idiroz								
be der		1 TO ALCOHOLOGICA (1975)					16	8. MOTHE			iddle, Maiden			
Ed by	띪	Sandy P	reston Th	nomas							ae J			
Fage 6 may be retained by the hospital director, page 5 should be detached to retain must be notified at once.	2	19a. INFORMANT'S NAME (Type/Print)									or, City or Tow			
ay be re page 5		Kenneth R. Creas	У		PO Bo	ox 765), R1	ı age.	ΙΥ,	Mary	Tand	2166	50	
. Page 6 may b ral director, pag		20a, METNOD OF DISPOSITION 1 X Burial 2 Cremation 3 Rem	oval from State	20b. PLACE A cemetery, crei			ON (Neme	of		OATE	20c. LO	CATION —	City or To	wn, Steta
MOR age 6 ma director, g	9.	4 Donation 5 Other (Specify)		Ridge			Cy_			11/	15 Ri	dge1	, Ma	ryland
AL I IN death. Pag funeral di examiner		21. SIGNATURE OF FUNERAL SERVICE LIC	DENSEE				ME AND A			ILITY				
ter death. P the funeral wal.		0.4	Mone								e, P.		0.0	600
	\dashv	23 Basic Senter the discourse or			-41- 10-	Di	cawer	r B,	Der	iton,	Mary	land		629
hours after ed in by the or remova	- 1	23 PART Enter the diseasea, or shock, or heart failure.	List only one cause	e on aach line	atn. Do n	ot enter th	e moda	ot dying	g, auch	as cardi	ac or reapi	ratory an	reat,	Approximata interval Between
ted within 27 hours completely filled in ial, cremation, or re event, the med	III.	IMMEDIATE CAUSE (Final	0	0	11/	<u> </u>			1					Onset and Death
within any pletely fille cremation, rent, the		disease or condition resulting in death)	. SMAL		1	SACI	mo,	Ma	6	545				144
ompletel ompletel I, crema		disease or condition resulting in death) a. Small Calcumona Cung DUE TO (OR AS A CONSEQUENCE OF): 3. STALL DUE TO (OR AS A CONSEQUENCE OF): 3. STALL DUE TO (OR AS A CONSEQUENCE OF): 3. STALL DUE TO (OR AS A CONSEQUENCE OF): 3. STALL DUE TO (OR AS A CONSEQUENCE OF): 3. STALL DUE TO (OR AS A CONSEQUENCE OF): 3. STALL DUE TO (OR AS A CONSEQUENCE OF): 3. STALL DUE TO (OR AS A CONSEQUENCE OF): DUE T										1		
executed within and completel o burial, crema	Z	Sequentially list conditions,	5 M	275	300	139	754	10						6 1705
Ox 60 be execut sician and c rior to buris traumatic	ERTIFICATION	it any, leading to immediate	DUE TO (O	R AS A CONSEC	CONSEQUENCE OF):									
0 8 80	2	cause. Entar UNDERLYING CAUSE (Disease or injury	a (' () I										10 yes
	분	that initiated eventa resulting in death) LAST	DUE TO (C	OR AS A CONSEC										
7 8 8 4 9	EH	resorting in death) Exs	d									_		
the death y the attend Mental	O	PART ii. Other aignificant condition	a contribution to d	eath but not r	equition i	in the unde	andrian or	euroe elu	ion in f	Daret I	04- 440 44			
A and at I	EDICAL			odiii bat iiot ii	aauting i	iii tire uride	arrying ca	auaa giv	veii iii r	art I.	24a. WAS AN PERFOR		240.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ires that signed b tealth an	ă									- 1	1 YES 2	□ NO		OF DEATH?
requires been sign of Heal	M									_				1 YES 2 NO
law ra law ra as ber Dept. 23 si	AN													
ATTENDING PHYSICIAN: The law requires th SCOR: After this certificate has been signed a siter death with the State Dept. of Health 28 is marked, or Item 23 shows an	S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:				26. PLACE	E OF DEA	ATH (Che	ck only one)			
MAN: Intification of the	SICI	1 TYES 2 THO	1 Inpatient 2 1	ER/Outpatient 3	□ DOA	OTHER:	g Nome !	5 🗆 Rask	idence (Other	(Specify)			
this cer with the	PHY	27. MANNER OF DEATH	28a. DATE OF the (Month, Day,		28b. TIM	E OF 28	Bc. INJURY WORK?			28d. DE\$C	CRIBE HOW I	NJURY OC	CUREO	
NG PHYY fer this sath with	ВУ	1 Latural 5 Pending 2 Accident Investigation	(Moran, Day,	, rour)	INS		1 YES		NO					
NDING Hearth death		3 Suicide 8 Could not be	28a. PLACE OF building, et	INJURY — At ho	me, farm, a	street, factory	y, office			281. LOCA	TION (Street s	nd Number	or Rural R	loute Number,
TOR: after	ш	4 Nomicide determined	burioning, et	ic. (Specify)						City or	Town, State)			
R H H	MPLET	29a, CERTIFIER CERTIFYING PHYS	CIAN: To the heat of m	n kasulada - d-	adb a salar	4 44 45 45					Jan Salates	V (- 1) (-		
# 28 F	₹ I	(Check only one) 2 MEDICAL EXAMINE	CIAN: To the best of m											
UNE	8		~	mineron and/or i	riveatigatio	ii, iii my opir	non, geatr	n occured	at the t	ime, data a	ind place, an	d dua to th	ne cause(a)	and manner as stated.
를 를 하는 다.	BE	296. SIGNATURE AND TULE OF CERTIFIE	T				29	C. LICEN	SE NUM	BER	_	29d. OAT	E SIGNED	(Month, Day, Year)
TO THE HOSPITAL OF TO THE FUNERAL DE FIEG WITHIN 72 PR	6	477	0110	m			Marina	H	40	028			111	2/94
	-	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE	OF DEATH (ITEN	4 27) (Type,	Print)								*
	1	Henry R. DiTomma	aso, M.D.,	PO Box	122	, Gol	dsbo	ro,	Mar	y1and	1 216	36		
		31. OATE FILED (Month, Day, Year)	32. REGISTRAR	'S SIGNATURE										
	- 1	NOV 1 1, '91	TO The	٠ ١٠ ٠										

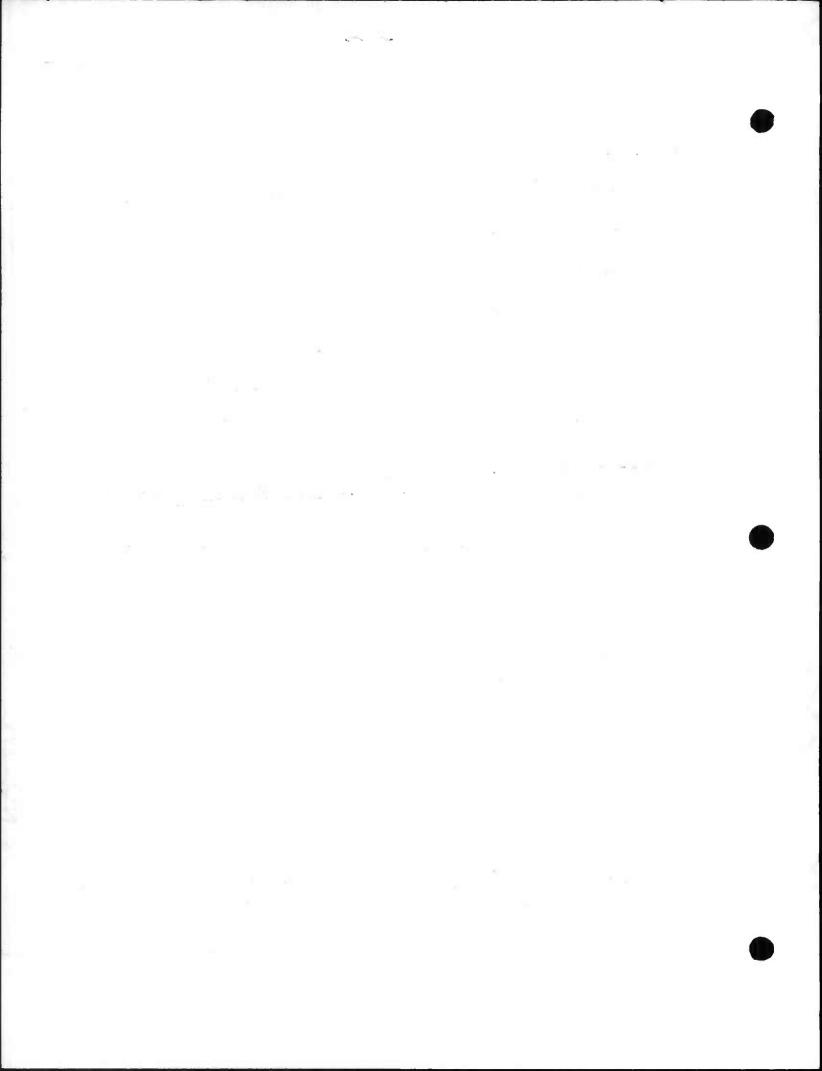
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a floor after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM				GIENE G. NO.			
	t. DECEDENT'S NAME (First, Middle, Last)	ebston EDW	IN HANSON	WEBST	ER	2. DATE OF DE	ZS - 90	YEAR 3. TIME OF DEATH		
	015 05 1011	SEX 6. AGE (III		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BII (Month, Day, May 9,	RTN (bar)	B. BIRTHPLACE (State or Foreign Country) Virginia		
TOR	99. FACILITY NAME (If not distitution, give stree 3/37 walls	and number)	96	lur	R LOCATION OF D	EATN	9c. COUNT	TY OF DEATH		
DIRECTOR	10e. STATE 10b. COUNTY	arford	10c. CITY, TO	OWN OR LOCAT		chville	2	10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	100. STREET AND NUMBER 3137 Snake Lane			tor	ZIP CODE	28	10g. CITIZI	EN OF WHAT COUNTRY? USA		
BY FUN		2. WAS DECEDENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DAT KOYEAN	If yes, spi	ENDENT OF HISPA icity Cuben, Mexico 2000 Special	NIC ORIGIN? (Spi	atc.)	14. RACE — American Indien, Black, White, etc. Specify:			
ETED		ION	16a. DECEDENT'S USU (Give kind of work life. Do NOT use rel	done during mos ired.)	st of working		OF BUSINESS/INDU			
COMPLETED	10 17. FATNER'S NAME (First, Middle, Last) Joseph Ignatius Wel	Maste	er Mech	16. MOTNER'S NA	AME (First, Middle,		nt Sales			
Joseph Ignatius Webster Nan Miriam Poole 190. INFORMANT'S NAME (Type/Print) Daniel I. Webster Nan Miriam Poole 191. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3135 Snake Lane, Churchville, Maryland 2102										
	20e METHOD OF DISPOSITION Section Characteristic Burlai 2 Cremetion 3 Femore from State									
7	23. PAIT I. Enter the diseases, or compands, or heert fellure. Lie iMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	artinus	the deeth. Do not e	enter the mod	de of dying, suc	ch as cerdiec o	r reepiratory erre	et, Approximeta		
CERTIFICATION	Sequentielly liet conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted eventa reaulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
AL.	PART II. Other algnificent conditions of LOCAL	ontributing to deeth bu	t not resulting in the	e underlying	ceuse given in		WAS AN AUTOPSY PERFORMED? YES 2 100	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 (NO		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL EXAMINER?		6. PLACE OF DEATH (C		UNCERTAI	N 🗆 📗				
BY PHYSI		Dispatient 2 ER/Outpat 28e, OATE OF INJURY (Month, Day, Year)	100A 4 C	Nursing Home 26c. INJU WOI			NOW INJURY OCCU	PRED		
	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY - building, atc. (Specifi	At home, farm, atreel	, factory, office		281. LOCATION City or Town	(Street end Number of 1, State)	r Rural Route Number,		
COMPLETED		N: To the best of my knowle On the baels of examination						f. cause(e) end manner ee stated.		
TO BE (290. SIGNATURE AND TITLE OF CERTIFIER JULIANA J. C. 30. NAME AND ADDRESS OF PERSON WHO CO	efuns			29c. LICENSE NUI	ME	11	SIGNED (Month, Day, Year) 1/28/94		
	RICHARD J.	COLI-E.	R, MD	1	20137. DAR	RAPPL	CHUR ON, M	PH RUAD 21034		
	NOV 3 U 1984	jahi Davidson	Reveal							



		Pages	
BALTIMORE, MARYLAND 21215-0020	ours after death. Page 6 may be retained by the hospital or attending physician.	ed in by the funeral director, page 5 should be detached for use as the burial-transit permit. P , or remoral.	
DIVISION OF VITAL RECORDS, P.O. BOX 68/60.	AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with dours after death. Page 6 may be retained by the hospital or attending physician.	AL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 12 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	

	1. DECEDENT'S NAME (First, Middle, Last)			ERTIFICA		DEAIII	REG. N 2. DATE OF DEATH MONTH		YEAR 3. TIME OF D		
	ALMA	- 0		WISE			November 28, 1994 4:05				
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	yrs. IF U	HS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		D. BIRTHPLACE (State of Country)		
	215-09-6888 9s. FACILITY NAME (If not institution, give s	1 M 2XXF	77	13.88	CITY TOWN	OR LOCATION OF D	12-31-19		Indiana		
E E	Bel Forest Nursin		bilitat			Forest		rford			
DIRECTOR	RESIDENCE OF DECEDENT										
IRE	10a. STATE 10b. COUNT			10c. CITY, TOV		ATION			10d. INSIDE (
	Maryland Harfo	rd		Falls		Of, ZIP CODE			1 TYES 2		
BY FUNERAL	2107 Belgian Ct.					21047		EN OF WHAT COUNTR			
S	11. MARITAL STATUS	12. WAS DECEDEN	IT EVER IN U.S. A	RMED			NIC ORIGIN? (Specify	4. RACE - American			
F	1 Never Married 2 Merried	FORCES? 1	YES 2X	NO	If yes, s		en, Puerto Rican, etc.)	Black, White, atc. Specify:			
COMPLETED BY	3 Widowed 4 Divorced								White		
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(0	ECEDENT'S USUA Give kind of work de	one durina m	TION nost of working	16b. KIND OF BUSINESS/INDUSTRY				
	Elementary/Secondary (0-12)	College (1-4 or 5	+}	e. Do NOT use retin			C S D Tolombons				
MC	12 Grade		Dus	siness N	lanage		C & P Telephone				
	To. Father's NAME (First, Middle, Last) John B. Hurtt Ursula U/K Case:										
	100 INFORMANT'S NAME (Top (South										
5	John R. Baker Sr.			2101 Hac	kney	Ct. Fai	llston,Mar	yland	21047		
	20e. METHOD OF DISPOSITION 1 ◯ Buriel 2 □ Cremetion 3 □ Rem	oval from State	20b. PLACE	AND DATE OF DIS	POSITION /	Vame of	OATE 20c.	LOCATION - CI	Ity or Town, State		
	4 Donation 6 Other (Specify)		High		-	1 Gardens	s 12-1-94	Falls	ton, Maryl		
	23. PART I. Enter the diseases, or ehock, or heart failure. iMMEDIATE CAUSE (Finel disease or condition moulting in death)	List only one ceu	ise on each lin	e.	nter the m	ode of dying, su	ry Rd. Abi	ngdon,	Maryland st, Approx Interva Onset		
	resulting in death)	OUE TO	(OR AS A CONSE	EOUENCE OF):	me	u					
Z	Sequentielly list conditions,		quen		-						
FICATION	if any, leading to immediate	DUE TO	(OR AS A CONSE	EOUENCE OF):	- 111						
FIC	CAUSE (Disease or Injury that initiated events Due to (off as a Consequence or)										
CERTI	reaulting in deeth) LAST	CA	wee	Ester							
	24.07 11.00										
MEDIC	PART II. Other significent condition	is contributing to	deeth but not	resulting in the	underlyli	ng ceuse given is	PERF	AN AUTOPSY FORMEO? 2 NO	24b. WERE AUTOPS AVAILABLE PR COMPLETION OF DEATH? 1 YES 2		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL										
SICI	EXAMINER?	HOSPITAL:	- FD/Outrations		HER:	PLACE OF DEATH (C					
H	27. MANNER OF DEATH	1 Inpatient 2 I	INJURY	28b. TIME OF		me 5 Residence	8 Cher (Specify) 26d. DESCRIBE HON	W INJURY OCCU	IRFO		
-	1 Natural 5 Pending	(Month, D	lay, Year)	INJURY	W	YES 2 NO					
	2 Accident 3 Suicide 4 Nomicide 4 Nomicide 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route No. (Specify) 28t. LOCATION (Street and Number or Rural Route No. (Specify)										
COMPLETED BY PH	O Codid Not be	building,	atc. (Specify)				only de nomin, one				

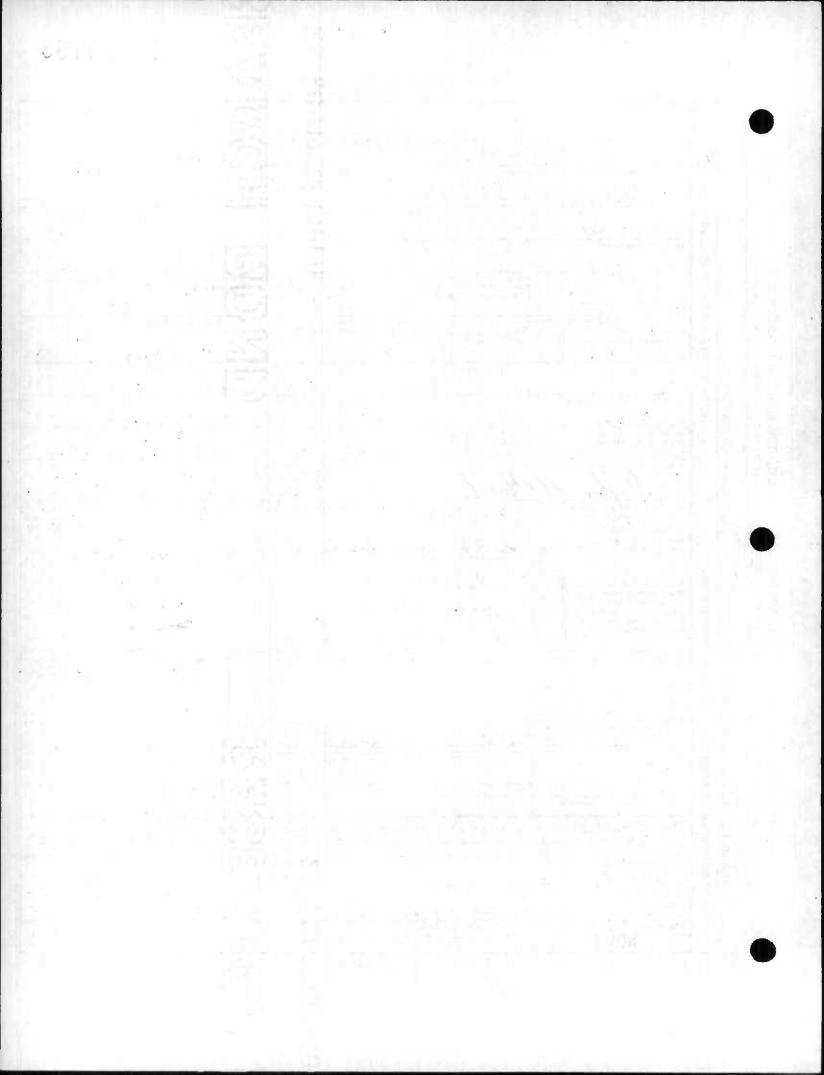
DAUD 5-DUNN 1131 Belain Parlall

31. DATE FILED (Month, Day, Year)

NOV 3 0 1994

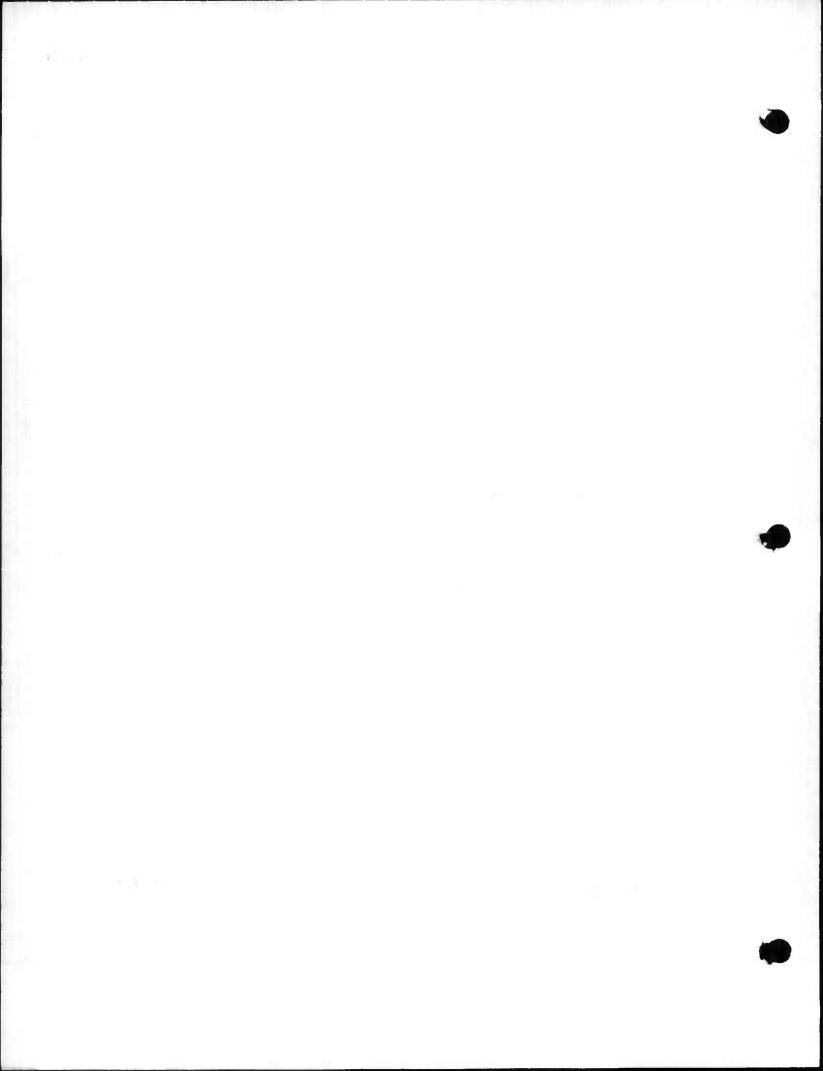
32. REGISTRAP'S SIGNATURE

NOV 3 0 1994



8/60, BALIIMORE, MARYLAND 21215-0020	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the most after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, nage 5 should be detached for use as the busial-transit narmia page 4. 2 a hand	rial, cremation, or removal.	ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
CINISION OF VILAE RECORDS, P.O. BOX 88760,	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be exec	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumati	

	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPAR	TMENT	OF H	EALTH	AND	MENTAL	HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last) Virginia Rosella WO							MONTH	OF DEATH	AY	YEAR QQL	3. TIME OF DEATH
	214-09-9738	□ M 2 □XF 78	s. leat birthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS.	7. DATE (PE BIRTH Day, Year) 16,1		8. BIRTHS Country	A:15 A PLACE (State or Foreign ryland
TOR	9a. FACILITY NAME (If not institution, give street 416 Indiana Avenue RESIDENCE OF DECEDENT	and number)				STOW.		EATH		9c. COUN Wash	ingt	
DIRECTOR	Maryland Washing	ton	1	y, town o		ION						10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	100. STREET AND NUMBER 416 Indiana Avenue				101.	217				USA	HAT COUNTRY?	
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR OATES	X NO	H	yes, spe	ENDENT O celfy Cubar 2 X NO	n, Maxica	n, Puarlo R	(Specify Yea can, etc.)	or No-	14. RACE Black, Specify Whit	
15. DECEDENT'S EQUATION (Specify only highest grade completed) Elementary/Secondary (0-12) To Father's NAME (First, Middle, Last) 10. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working kind. Do NOT use retired.) 10. MOTHER'S NAME (First, Middle, Last) 11. FATNER'S NAME (First, Middle, Last) 12. Company N. Company (0-12) 13. MOTHER'S NAME (First, Middle, Maiden Surname)												
COMP	17. FATNER'S NAME (First, Middle, Last)	0	homem	aker		18. MOTH	ER'S NA		er ow		ie	
BE	Lester N. Conner		19b. MAILING	1000500		Can	roli	ne B.	Mart	in		
2	Patricia A. Morgan											ld.21795
	20a. METNOD OF DISPOSITION 1 1 Burlal 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State cometery, Rest	ceand date of crematory or of Have	her place!			L2 – 6	-94		ersto		n, State
	21. SIGNATURE OF FUNERAL SERVICE LICENSI	Munich	2	MÎN	NI CI	ADDRES FUN	S OF FA	CILITY L HOM	E			Md. 21740
	23. PART i. Enter the disessea, or companock, or heart failure. List iMMEDIATE CAUSE (Final disease or condition resulting in deeth)	olicationa that caused the only one cause on each Renal Fa.	line.	ot enter i	the mod	le of dylr	ng, auci	h aa cardi	ac or respi	ratory arre	est,	Approximate interval Between Onset and Death
	a	Diabetes		,	Пето	. TT						years
CATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CON			тАЪ	6 11						yrs
CERTIFICATION	CAUSE (Disease or injury that initisted eventa resulting in death) LAST	DUE TO (OR AS A CON	SEQUENCE OF):								
A L	PART II. Other algnificant conditions co	ntributing to death but no heimer's Dis		n the und	lerlying	cause gl	ven in		PERFORI	MED?	1 6	WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL										1	YES 2 NO
SICI	EXAMINER? HO	SPITAL: Inpatient 2 - ER/Outpatient	3 DOA	OTHER:				6 Other	Specific			
	27. MANNER OF OEATN 1 Annual 5 Pending	28a. OATE OF INJURY (Month, Day, Year)	28b. TIME INJ	OF 2	8c. INJU WOR	RY AT			RIBE NOW IN	JURY OCCU	PREO	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide datermined	28e. PLACE OF INJURY — At building, etc. (Specify)	home, ferm, a	treet, factor			NO I	28f. LOCAT City or	ION (Street at Town, State)	nd Number o	r Rural Roo	ute Number,
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: 2 MEDICAL EXAMINER: On	To the best of my knowledge, the basis of examination and/	death occurre	d at the tim	ne, data a	nd place,	and due t	to the cause	o(s) end man	ner as stated	i. cause(s) s	and manner as stated.
8	296. SIGNATURE AND TITLE OF CERTIFIER	mo				29c. LICEN		BER		29d. DATE		Month, Day, Year)
2	30. NAME AND AODRESS OF PERSON WNO COMBARTY M. Cohen,				riv	e, H	ager	stown	ı, MD	2174		
	31. DATE FILEO (Month, Day, Year) DEC 0 6 1994	32. REGISTRAR'S SIGNATURE	24-	ii .								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dupt. of Health and Mental Hygiens prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. **BALTIMORE, MARYLAND 21215-0020** DIVISION OF VITAL RECORDS, P.O. BOX 68760

1. DECEDENT'S NAME (First, Middle, L			TE OF DEATH	MENTAL HYGIENE REG. NO.		
	s LAWRENCE WIN	BORNE		2. DATE OF DEATH	1994	3. TIME OF DEATH 10:50 A. M
4. SOCIAL SECURITY NUMBER 227-03-7288	1 X M 2 F	83 YRS. MONTI	31 Z/01 11=20 1311	7. DATE OF BIRTH (Month, Day, Year) 9/2/1911	Nor	th Carolina
90. FACILITY NAME (If not institution, g 16840 Henderso	n Rd. Lot 6	9b. C	Henderson	EATH	county of c	
10a, STATE 10b, CO		10c. CITY, TOW Hende	ON OR LOCATION			10d. INSIDE CITY LIMITS? 1 YES 2 X NO
100. STREET AND NUMBER 16840 Henderso			101. ZIP CODE 21640		USA	WHAT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D.	2 X NO	13. WAS DECENDENT OF HISPAI If yes, specify Cuben, Maxica 1 YES 2 NO Specifi	in, Puerto Rican, etc.)	No 14. RAC	E — American Indian, ik, White, atc.
15. DECEDENT'S (Specify only highest of Elementary/Secondary (0-12) 3 17. FATHER'S NAME (First, Middle, Last	completed) College (1-4 or 5+)	life. Do NOT use retire	one during most of working ad.) gengineer		on Unic	on of Oper- Local #147
Franklin Winbo	rne	19b. MAILING ADDR	Margar RESS (Street and Number or Rural	ret Elizabet Route Number, City or Town,		ey
Lora Mae Winbo	206	. PLACE AND DATE OF DIS	enderson Rd. I		rson, M	
4 Donation 5 Other (Specify). 21. SIGNATURE OF FUNERAL SERVICE		etery, crematory, or other pla Greensboro	22. NAME AND ADDRESS OF FA Fleegle-Hel			ome
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	bDUE TO (OR AS A	CONSEQUENCE OF):	Kid	O .		400
resulting in death) LAST						
	itions contributing to death to	out not resulting in the	underlying cause given in	Part I. 24a. WAS AN AL PERFORM 1 YES 2	ED7	WERE ALTOPSY FINCHINGS MARLANE PHORIT TO COMPLETION OF CALISE OF DEATH? 1 YES 2 NO
resulting in death) LAST	lung HOSPITAL:	om om	24. PLACE OF DEATH (C)	PERFORM 1 YES 2 ()	ED7	MARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PART II. Other significant cond 25. WAS CASE REFERRED TO MEDICA EXAMINERY 1 VES 2 NO 27. MANNER OF DEATH 1 Parties 5 Pending	HOSPITAL: 1 Inpatient 2 Ethoute (Monot, Day, War)	om om	24 PLACE OF DEATH (C)	PERFORM 1 YES 2 ()	1410	MARLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PART II. Other significant cond 25. WAS CASE REFERRED TO MEDICA EXAMINERY 1 VES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpellent 2 ENOuts (Mont, Des. Wer) 28e. PLACE OF INJURY building, etc. Size	ontlent 3 DOA OTE	28. PLACE OF DEATH (C) HEFI: Numing Home 5 Pasidence 38c. INJURY AT WORK? 1 YES 2 NO	PERFORM 1 YES 2 () sectionly and	LINY OCCURED	MARABLE PHORN TO COMPLETION OF CAUSE OF CEATHY
PART II. Other significant cond 25. WAS CASE REFERRED TO MEDICA EXAMINERY 1	HOSPITAL: 1 Inpellent 2 ENOuts (Mont, Des. Wer) 28e. PLACE OF INJURY building, etc. Size	antient 3 DOA 4 DOA 4 DOA AID NOW AIR home, tarm, street, only ledge, dasth occurred at t	26. PLACE OF DEATH (CATALOGUE) ABER: Number 5 Residence 25c. Number 4 November 4 November 7 November 7 November 7 November 9 Novem	PERFORM 1 YES 2 1 YES 2 2 Other (Specify) 2 DESCRIBE HOW INJ 2 ST. LOCATION (Street acc City or Sweet, State) 1 to the cause(s) and manner	Winner or Russi	MARABLE PHORN TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 □ NO Pount Number
PART II. Other significant cond 25. WAS CASE REFERRED TO MEDICA EXAMINERY 1 VS 2 NO 27. MANNER OF DEATH 1 Astures Pending Investigat 3 Suitsde Could not determine 29e. CERTIFIER (Check only	HOSPITAL: 1 Impatisent 2 Ethouts 2ttle DATE OF INJURY (Mondy, Day, Wast) 2ttle PLACE OF INJURY building, etc. (Spe	antient 3 DOA 4 DOA 4 DOA AID NOW AIR home, tarm, street, only ledge, dasth occurred at t	26. PLACE OF DEATH (CATALOGUE) ABER: Number 5 Residence 25c. Number 4 November 4 November 7 November 7 November 7 November 9 Novem	PERFORM	UMY OCCURED Winther or Rural or as stated.	MARABLE PROPINTO COMPLETION OF CALISE OF DEATH) 1 YES 2 NO Route Wurster

65.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. Jours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

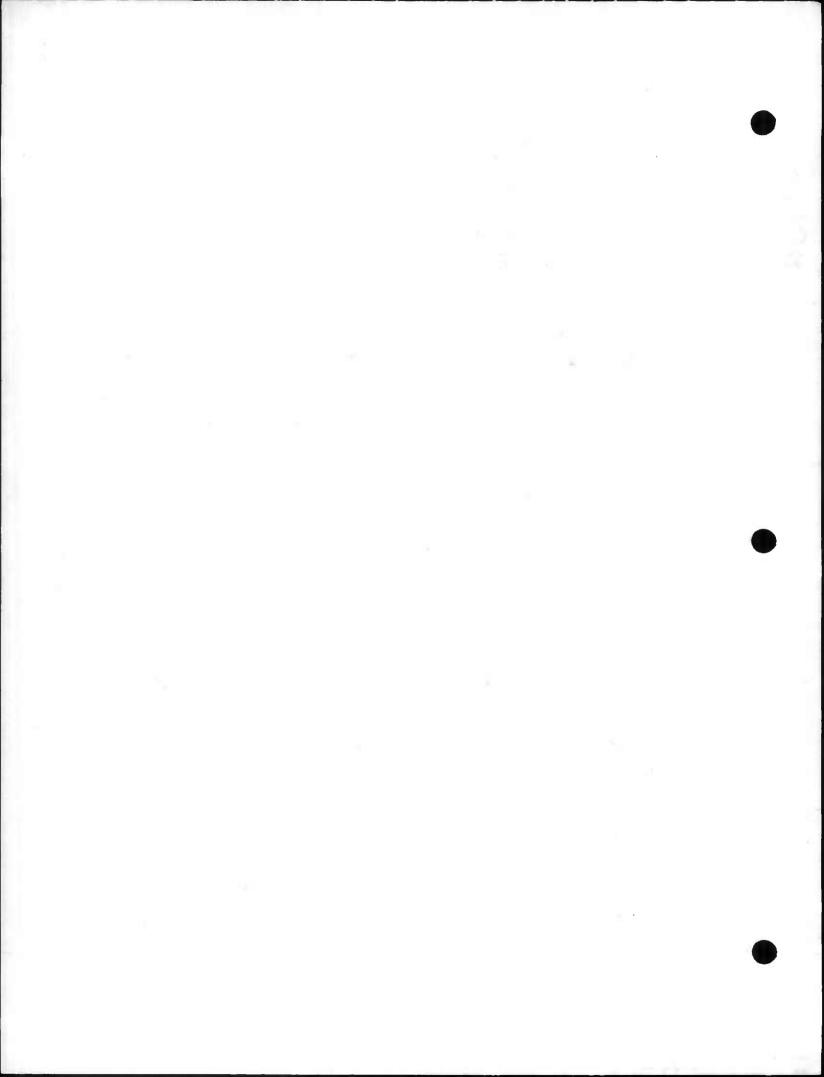
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,	Middle, Last)									2. DAT	E OF OEATH			3. TIME OF OEATH
li	Blanche	T D	awson W	alch							1 (_	1	94	12:10 PM
	4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (In	yrs. lest b	oirthday)	IF UNDER		IF UNDE	24 HRS.	7. DAT	E OF BIRTH		S. BIRTN	IPLACE (State or Foreign
	213-03-07	8 4	1 ☐ M 27☐XF		77	YRS.	MONTHS	DAYS	HOURS	MIN.		nth, Dey, Year) !	7	M a	η rvland
	9s. FACILITY NAME (If not in	stitution, give s	freet and number)				9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY C								
6	Meridian -	- The	Pines			_	Easton				Talbot		ot		
DIRECTOR	RESIDENCE OF DEC	10b. COUNTY													
E					10c. CITY	Y, TOWN I	OR LOCAT	ION						10d. INSIDE CITY LIMITS?	
	Maryland Talbot 10c. STREET AND NUMBER										sto	n			CXYES 2 NO
RA								101	. ZIP COD	2160	0.1		_		YNAT COUNTRY?
FUNERAL	Route 50 & Dutchman's Lane 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED				rn.	140	400 DEC	CALDENIA A			IN? (Specify Yes			States	
ᇤ	1 Never Married 2	Married	FDRCES? 1	YES	2 K NO)		If yes, sp	ecify Cubi	n, Mexics	n, Pusrto	o Rican, etc.)	or No-		— American Indian, k, White, stc.
BY	3 X Widowed 4 Divo	rced	17 123, 0172 1	WIN ON DAI	169			I U TES	2 KND	Specify	γ:			Speci	White
COMPLETED		EDENT'S EDU			16s. DECE	DENT'S	USUAL O	CCUPATIO	ON et of work	20	16	Bb. KIND OF BUS	INESS/IN	DUSTRY	
	Elementary/Secondary (0		College (1-4 or 5	+)					st of world						
₹	Tenth				(Cir	cula	atio						aper	rs
	17. FATNER'S NAME (First, M									_		, Middle, Maiden S	,		
H	19s. INFORMANT'S NAME (7	*	illiam	wnar								ewbler			
유	Virginia		Raccatt	Δ								nber City or Town			001
	20e. METNOD OF DISPOSIT		0033611	_	PLACE AN					reei	_	TE 20c. LOC			
	1 Surisi 2 Cremetic	n 3 🗆 Rem	oval from Stats	cemei	tery crems	atony or of	her niacel				1				
	21, SIGNATURE OF FUNERA		ENSEE	<u> </u>	111	UT	22.	NAME AN	D ADDRE	SS OF FAC	CILITY	<u>-5] red</u>	era	ISDU	irg, MD
	▶ m.l.	01	G Dans				F	amp	tom	-Hav	wki	ns-Esk	OW	Fune	eral Home
	22 BART i Seter the di	4 7.	Calciro												21632
	23. PART i. Enter the di shock, or h	eart failure.	List only one cer	ise on eed	ch line.	n, Do n	ot enter	tne mo	de of dy	ing, suct	h es ca	rdiac or respir	ratory ar	rest,	Approximete interval Between
	iMMEDIATE CAUSE (Fir disease or condition		40		-		~	,							Onset and Death
ŀ	resulting in death)	7	a. DUE TO	(OR AS A C	CONSEDU	ENCE OF	7: 8	all	سحا						>lyr.
2			DUE TO	elm	ner	1-1			. 0						
CERTIFICATION	Sequentially list conditi If any, leading to imme-	ions, diate	DUE TO	(OR AS A C	CONSEDU	ENCE OF	7:0		p.v.	A SOUTH	N SA				12 Mary
S	cause. Enter UNDERLYi CAUSE (Disease or inju		с												
F	thet initieted events	T	DUE TO	(OR AS A C	CONSEDU	ENCE DE	7:								
5			d												
	PART ii, Other significe	nt condition	s contributing to	deeth but	t not res	ulting i	in the ur	nderlying	cause	given in	Part i.	24a. WAS AN		24b	WERE AUTOPSY FINDINGS
EDICAL			No	re								PERFORI			AMILABLE PRIOR TO COMPLETION OF CAUSE
MEC													-		DF DEATN? 1 YES 2 NO
Y S	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL							ACE DF D	EATN (Che	eck only	one)			
YSI	1 TYES 2 ND		HOSPITAL:	ER/Outpet	tient 3 🗆	DDA	4 Sur		e 5 🗆 R	esidence	6 🗆 011	her (Specify)			
PHYSICIAN:	27. MANNER OF DEATN		26e. DATE DF (Month, E			26b. TIMI INJ	E OF URY	28c. INJ WO	URY AT		28d. D	ESCRIBE NOW IN	JURY OC	CURED	
B	2 Accident	Pending Investigation					M		/ES 2 [NO					
		Could not be	26e. PLACE C building,	etc. (Specif)	— At homs (y)	s, ferm, s	street, fact	tory, offic		- 1	26f. LO	CATION (Street at by or Town, State)	nd Numbe	r or Rural I	Route Number,
COMPLETED															
鱼			CIAN: To the best of												
8	2 MEDI	CAL EXAMINE	R: Dn the basis of s	xamination	end/or Inv	reatigatio	n, In my c	opinion, d	eath occu	red at the	time, de	te and place, end	d due to t	he csuse(s	s) end manner es stated.
ш	296. SIGNATURE AND TITLE				-					ENSE NUM		T			(Month, Day, Year)
TO B	Robert					_				093					31-94
-	30. NAME AND ADDRESS OF	PERSON WH	O COMPLETEO CAU	SE OF OEAT	TN (ITEM :	27) (Туре,	Print)		_			0 1			
	KO bert	- W,	neve	7. /	М.	<i>V</i> .	70	096	0	can	m (rater	va	t, Ed	21601
	NOV 02	94	32. Bellestru	Davido	orc-No	indell	٢								21601



2. DATE OF DEATH

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1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

C ۵ RECORDS DIVISION OF VITAL

3	after
	24 MOURS
5	within
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	PHYSICIAN:
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	R
	OSPITAL 0

31. DATE FILED (Month, Day, Year)

NOV29

JUNG ANG EUN NOO. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) June 25, 1929 1 M 2 🗌 F 65 9a. FACILITY NAME (If not institution, give atreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Holy Cross Hospital the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 Silver Spring RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION Maryland Montgomery Silver Spring FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 11550 Stewart Ln, #509 20904 or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-II yea, specify Cuban, Maxican, Puerto Rican, atc.) FORCES? 1 YES 2 NO 1 Never Married 2 Married 1 WES 2 NO Specify. BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compo Elementary/Secondary (0-12) College (1-4 or 5+) the hospital 12 Officer Korean Military 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Sumame) notified at 2 Man Sung Yang Choi Yang Page 6 may be retained 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 11550 Stewart Ln, #509, Silver Spring, MD 20904 Seung Man Yang pe 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION --- City or Town, State must elery, crematory or other place)
Fort Lincoln Crematory Nov 28 Btentwood, MD examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home alan Donnelp 11800 New Hampshire Ave, Silver Spring, MD medicai 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errect, shock, or heart fellure. List only one cause on each line. filled in by **IMMEDIATE CAUSE (Finel** the disease or condition Beaut anterio selevotre resulting in death) event, DUE TO (OR AS A CONSEQUENCE OF): and com traumatic BY PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, physician ar DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury the attending physical Mental Hygiene p or other DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST been signed by the atten pt. of Health and Mental I 3 shows any injury, o PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 244. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMPLER?

1. YES 2 NO certificate ha h the State Do d, or item 2 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: me 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY this c 28b, TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, Natural 5 Pending Investigation 1 YES 2 NO After ti 2 Accident 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, stc. (Specify) 99 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town: State) COMPLETED 6 Could not be DIRECTOR: Journ after of item 28 is 4 Homicide 29e. CERTIFIER

(Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated, TO THE FUNERAL C be filed within 72 h IMPORTANT: If II 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 295. SIGNATURE AND TITLE OF CERTIFIER BE THE THE P 29c. LICENSE NUMBER D085 223 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 8218 W.SCMSIN 10 8 AUR

32. REGISTRAR'S SIGNATURE
JUNE DEVILOR - Pondalle

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

1 N YES 2 NO

Korean

Approximate Interval Between

24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 YES 2 NO

29d. DATE SIGNED (Month, Day, Year)

8.00CK

Bathola

Onset and Death

8. BIRTHPLACE (State or Foreign

Korea

9c. COUNTY OF DEATH

Montgomery

Korea

10g. CITIZEN OF WHAT COUNTRY?

Specify:

8: 53 pm

9



994

Maryland

Frederick

U.S.A.

O'CONNER

21701

3. TIME OF DEATH

10:40

BIRTHPLACE (State or Foreign Country)

10d. INSIDE CITY

14. RACE — American Indian, Black, White, atc.

specify: White

1 YES 2 NO

21701

Approximate interval Betw

10d

Onset and Death

use as the burial-transit Page 6 may be retained by the hospital or attending physician. **MARYLAND 21215-0020** 10 funeral director, page 5 should be detached the the filled in by been signed by the attending physician and completely filled it, of Health and Mertral Hygiene prior to burial, cremation,

Pages 1, 2, 3 should

permit.

DIRECTOR

FUNERAL

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COMPLETED

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the medical examiner

Injury, or other traumatic CERTIFICATION

MEDICAL

PHYSICIAN:

87

COMPLETED

BE. 2

BALT	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Hours after death,	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funerabe filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical exami
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	he de	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	njury
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH монтн 11 VIOLA ELIZABETH
4. SOCIAL SECURITY NUMBER 5. SEX ZIMMERMAN 29 7. DATE OF BIRTH (Month, Day, Year 5 SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS 1 M 2 X 215-14-1107 71 Sept. 21,1923 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Citizens Nursing Home Frederick RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Maryland Frederick Frederick 10e. STREET AND NUMBER 10f. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? 5463 Aylor Drive 21701 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: FORCES? 1 YES 2 1 Never Married 2 Merried 3 Wildowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high College (1-4 or 5+) Elementary/Secondary (0-12) Waitress Restaurant 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) David HARDMAN Harriet 19a. INFORMANT'S NAME (Type/Print) Gwendolyn E. Williams 5463 Aylor Drive, Frederick, Md. 20e. METHOD OF DISPOSITION
1 ☐ Burlel 2 \(\tilde{\Delta} \) Cremetion 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State OATE Smithsburg Crematory, 12/1/94 Smithsburg, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Md. Allan M00703 23. PART I. Enter the diseases, or complications det caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algorificent conditions contributing to death but not resulting in

Hyp	Chillegroides				PERFORMED? 1 YES 2 NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATH	(Check only o	ne)	
EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpatient	3 DOA 4 N	ER: ursing Home 5 🗆 Residen	ce 6 🗆 Oth	er (Specify)	
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	26d, DE	SCRIBE HOW INJURY OCCU	JRED
3 Suicide 6 Could not be determined	28e, PLACE OF INJURY — At I building, etc. (Specify)	nome, farm, atreat, f	actory, office	20f. LO	CATION (Street end Number of rown, State)	r Rural Route Number,

29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(e) end manner ee stated.

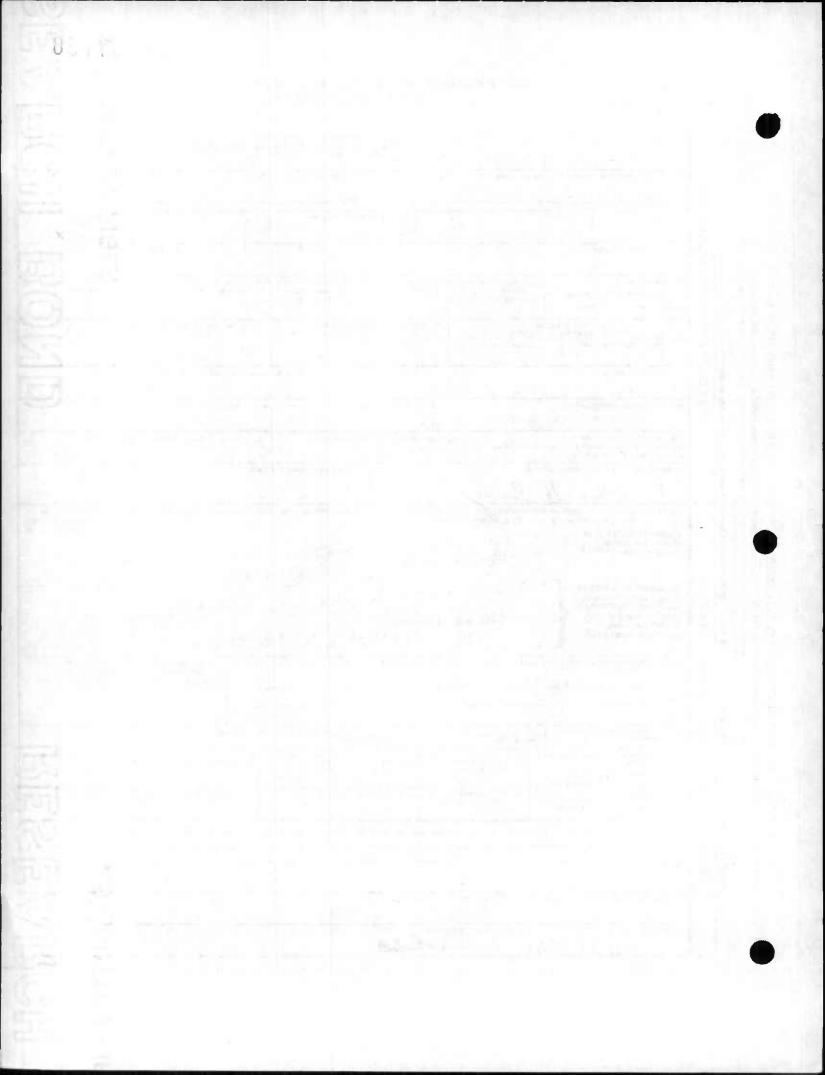
2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner se stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Yhalunid () / terris	NIZILNA	1 70 00

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

Dr. Bernard O. 7	homas, Jr., M.D.	, 1900	Rosemont	Avenue,	Frederick,	Md.	21702
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE						

E FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
NOV 3 0 1994	Jahn Davelson Rarbet



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Fours after death. Page 6 may be retained by the hours TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detected within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

ransit permit. Pages 1, 2, 3 should

BALTIMORE, MARYLAND

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last	0				OF DEATH	2. DA	TE OF DEATH	VO.		3. TIME OF DEATH
IAT.	NET MARY Z	TMBLE					DEC 2	1994	YEAR	7.22 E
4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (in yrs.	lest birthday)			. 7. DA	TE OF BIRTH		8. BIRTI	HPLACE (State or Foreign
306-38-6761	1 🗆 M 2 💢 F	56	YRS.	MONTHS D/	AYS HOURS MIN.	APF	onth, Day, Year,	1938	COUM	ECLICUT
9a. FACILITY NAME (II not inativation, give NATIONAL NAVEL MEDIC				96. CITY, TO BETH	WN OR LOCATION OF ESDA	DEATN			UNTY OF I	
RESIDENCE OF DECEDENT 10e. STATE 10b. COUN	ITY		10c. Cl	TY, TOWN OR L	OCATION					10d. INSIDE CITY
VA. FAIR	RFAX		RE	ESTON						LIMITS?
10a. STREET AND NUMBER					101. ZIP CODE			10g. Cl	TIZEN OF	WHAT COUNTRY?
2413 FREETOWN DI					2209	1		J	J.S.A	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	NO YNO	If yo	DECENDENT OF NISF e, specify Cuban, Max YES 2 YMO Spe	ican, Puer			14. RAC Blac Spec	E — American Indian, ik, Whita, stc. iffy: WHITE
15. DECEDENT'S ED	DUCATION de completed)	16a.		S USUAL OCCU	PATION ng most of working		16b. KIND OF	BUSINESS/IN	DUSTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	Iffa. Do NOT L	use retired.)	g man or norming		Of Th	T HOME		
12 17. FATNER'S NAME (First, Middle, Last)	3		HOPIE	MAKER	40 4400000000	NAME (N HOME		
RALPH WILLIAM I	BAILEY				PHYLL		ONICA			
19a. INFORMANT'S NAME (Type/Print) JAMES ALLEN ZIMI	BLE				weet and Number or Run WN DR. RE					
20a METHOD OF DISPOSITION 1 A Burlel 2 Cremation 3 Re		20b. PLAC	E AND DATE	OF DISPOSITIO	N (Name of			LOCATION		own, State
4 Donation 5 Other (Specify)	moval from State	ARLI	CIÓN N	WIIOVAL	CEMETERY	12	2-7 AF	RLINGIO	N, VA	•
21. SIGNATURE OF UNERAL SERVICE I	LICENSEE A									
23. PART/ Enter the diseese, or ehock, or heart failure immediate cause (Final diseese or condition	r complications that b. Liet brily one cour	se on eech li	ine.	GRE 721	ME AND ADDRESS OF EN FUNERA ELDEN ST mode of dying, so	L HO	RNDON,			Approximata Interval Betwee Onset end De
we cock, or heart failure immediate cause. Enter UNDERLYING CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO	SEPTI	IC SHO SEQUENCE O	GRE 721 not enter the OCK OF): CELL COFF:	EN FUNERA ELDEN ST	L HO	RNDON,	spiratory e	rrest,	Approximate Interval Betwee Onset end De
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we cock, or heart failure immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO C. DUE TO C.	SEPTI (OR AS A CONS SQUA (OR AS A CONS	MOUS SEQUENCE C	GRE 721 not enter the OCK oe): CELL COP):	EN FUNERA ELDEN ST mode of dying, se	L HO. HE	RNDON, erdiac or re THE HE	spiratory e	O NEC	Approximate Interval Betwee Onset end De
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MAEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificant conditions in death) LAST PART II. Other eignificant conditions in death last investigation in death last investigation in death last investigation in death last investigation investigation in death last investigation in death las	B. Llet ovily one ceus e	SEPTI (OR AS A CONS SQUA (DR AS A CONS (OR AS A CONS death but no ER/Outpatient INJURY (OF ER/OUTPATIENT INJURY (OF ER/OUTPATIENT INJURY (OF ER/OUTPATIENT INJURY (OF ER/OUTPATIENT INJURY (OF ER/OUTPATIENT INJURY (OF ER/OUTPATIENT INJURY (OF ER/OUTPATIENT INJURY (OF ER/OUTPATIENT INJURY (OF ER/OUTPATIENT INJURY (OF ER/OUTPATIENT INJURY (OF ER/OUTPATIENT INJURY (OF ER/OUTPATIENT INJURY (OF ER/OUTPATIENT INJURY (OF ER/OUTPATIENT INJURY (OF E	CC SHO SEQUENCE CO MOUS SEQUENCE CO SEQUENCE CO ST reculting 3 DOA 28b. Till IN home, farm, deeth occur for investiget	GRE 721 not enter the OCK OF): CELL COF): OF): OTHER: 4 — Nursing ME OF JURY M 1 1, street, factory, rred at the time,	EN FUNERA ELDEN ST mode of dying, so mode of dy	OF To the line and the line, detumber 1582	PHE HE	AD ANI AN AUTOPSY FORMED? B 2X NO W INJURY O	CCURED CCURED CCURED COURSE	Approximate Interval Between Onset end De On

BALTIMORE, MARYLAND 21215-0020

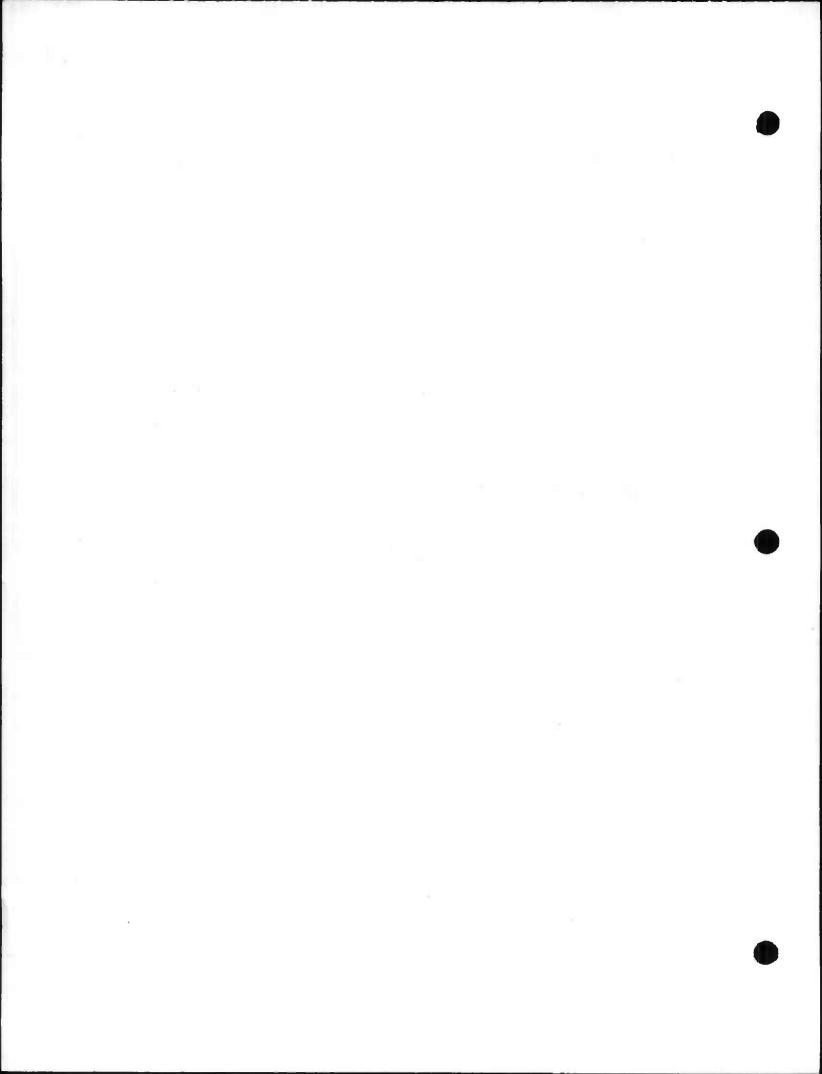
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an order of the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC				YGIENE EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF	DEATH		3	. TIME OF DEA	TH
	Arnold	Jacob	Zahnise	r		Novem	her		AR CO	1:56	DMM
	4. SOCIAL SECURITY NUMBER 5	S. SEX 6. AGE	(In yrs. last birthday) IF	UNDER t YEAR	IF UNDER 24 HRS.	7. DATE OF E (Month, Da	METH	8.	BIRTHPL Country)	ACE (State or Fi	preign
	714-07-4862 19a. FACILITY NAME (If not institution, give stree	t and number)	8 7 YRS.	NTHS DAYS	HOURS MIN.	05/04	4/07	9c. COUNTY	01	nio	
E E	Memorial Hospit			East		-AIH					
DIRECTOR	RESIDENCE OF DECEDENT							Tal	DOI		
뿚	10a. STATE 10b. COUNTY		10c. CITY, T	OWN OR LOCAT		LIMITS				Od. INSIDE CITY	′
		oline				nton			_	☐ YES 2 🔀	NO
RA	10e. STREET AND NUMBER				0.0	_		AT COUNTRY?			
FUNERAL		mony Road			216					State	
5	1 Never Married 2 Married	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	N U.S. ARMED	If yes, spe	ENDENT OF HISPAN cify Cuben, Maxica	n, Puarto Ricar		r No — 14.	Bleck, 1	 American Indi Whita, atc. 	an,
BY	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES	1 TYES	2 NO Specify	/ :			Specify:	whit	е
ED	15. DECEDENT'S EDUCAT (Specify only highest grade col	ION	16a. DECEDENT'S USI			16b. KIN	D OF BUSIN	IESS/INDUST	RY		
Ē		College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mos tired.)	at of working	De 1	iver	v of	Fi	1ms &	
MPL	9 t h		Truck D	river		1,01	News	pape	rs	. IIIIS &	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middl				Hammo	n d
BE (mar Zahni	ser		Lena C	oulbo	urne	Zah	nis	er	nu
0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street ar	nd Number or Rural I	Route Number, C	City or Town.	State, Zip Co	de)		
	Audrey Lee Zahn	iser	8812	Harm	ony Rd.	. Den	ton.	MD	216	29	
	20a. METHOD OF DISPOSITION 1 Burlat 2 Cremation 3 Ramova 4 Donation 5 Other (Specify)	ol from Stata cerr	PLACE AND DATE OF Dietery, crematory or other		ne of	OATE		TION — City			
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN	- W	oodlawn			1.7	East	on,	Mar	yland	
	> Michael 7.				otom-Ha		- Fek	OH F	11 n o	ral U	0.00
_				Fede	ralsbur	g, MD	216	32		Lai n	Ome
	23. PART I. Enter the diseeses, or con ahock, or heert fellure. Lis	nplications that caused	the deeth. Do not ech line.	enter the mod	de of dying, suci	h ss cerdlec	or reepira	tory errest		Approxim Interval B	
I	IMMEDIATE CAUSE (Finel	1) -	6.		1 .				Onset and	
	disesse or condition resulting in death)	K	espivai	· M	tark	ul				480	ms
		OUE TO (OR AS	CONSIGNOENCE OF)	-0	1 5 60	ini.				12/	
NO N	Sequentially list conditions, b.	OUE TO (OR AS A	CONSEQUENCE OF:	ny -	all	4 (7				304	7-5
ATI	If any, leeding to immediate cause. Enter UNDERLYING	00E 10 (0K A3 A	CONSEQUENCE OF):							/	- 1
티	CAUSE (Disease or Injury thet initiated events	OUE TO (OR AS A	CONSEQUENCE OF):							+	
CERTIFICATION	resulting in death) LAST										
	PART II. Other elgoificent conditions of	and other than the death to				-112				1	
NA I	PART II. Other algnificent conditions of	ontributing to death b	ut not resulting in t	he underlying	ceuse given in	Pert I. 24a	PERFORM		A	YERE AUTOPSY F	то
ă						10	YES 2	NO .		OMPLETION OF (F DEATH?	CAUSE
Σ	DID TODA GGO LIGT GOA TOUR								1	☐ YES 2 ☐	NO
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIE				UNCERTAIN	4 L.					
ö	EN AMERICA	OSPITAL:		THER:							
₹	27. MANNER OF DEATH	Inpatient 2 ER/Outp	28b. TIME O		5 Residenca				-		
	Netural 5 Pending	(Month, Day, Year)	INJURY	WOR		28d. DESCRIE	SE HOW INJ	DRY OCCUR	EU		- 1
B	2 Accident Investigation 3 Suicide B Could not be	28e. PLACE OF INJURY	— At home, farm, atree		2 2 10	28f. LOCATIO	M (Street and	Mumber or 6	Dural Bou	ito Mumbar	
	4 Homicide 8 Could not be	building, atc. (Spec	elfy)			City or To	wn, State)	Truttado de F	oren moo	Transon,	- 1
COMPLETED	29a. CERTIFIER CERTIFYING PHYSICIA	N: To the best of my knowl									
M I	(Check only one) 2 MEDICAL EXAMINER: ((a) a	nd manner es e	terest
	29b. SIGNATURE AND TITLE OF CERTIFIER	111	$\overline{}$								anteu.
B	Miton	Heres	mr	5	29c. LICENSE NUN	Man	2	DATE SI	J DBNE	fontil, Day, Year)	
임	30. NAME AND ADDRESS OF PERSON WHO C	OMPLETEO CAUSE OF OE	ATM (ITEM 27) (Type, Prir	11)	=111			. , ,	(1	(//	
	Thomas W. Faunt		/	,	Marve	1 C+	Fa	0+05	M	n 2166) 1
		32 REGISTRAR'S SIGN		.00	1101 46	± 01.	, Edi	S LOIL	141	1) 210() T
	31. OAT \$ 10EP (4001). Day 7041)	Julia Davids	ከ .								



BALTIMORE, MARYLAND 21215-0020	Mind and a second of the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	The section is seen some by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	on, or removal.	he medical examiner must be notified at once.
DIVISION OF WITH RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PHYSOMETIM IN INCIDENTS that the death certificate be executed within 2	TO THE FUNERAL DIRECTOR. Are the period of the attending physician and completely	be filed within 72 hours after treath with the Start Days of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked in the control above any injury, or other traumatic event, the medical examiner must be notified at once.

							2 -8	0 1	101	
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /	DEPARTMENT ERTIFICATION	T OF HE	ALTH AND I	MENTAL HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH			TIME OF DEATH	
- 1	Bobbie Ande				December 8, 94			:08 A M		
17	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last		R 1 YEAR	IF UNDER 24 HRS.	T DATE OF BURNE		8. BIRTHPLA	MCE (State or Foreign	
1		1X M 2 🗆 F 58	YRS. MONTHS		HOURS MIN.	May 24	36	South(Carolina	
~	9a. FACILITY NAME (If not institution, give str	,			LOCATION OF DE		9c. COUNT	TY OF OEAT	Н	
DIRECTOR	2123 Division Street Baltimore City									
REC	10a. STATE 10b. COUNTY		10c. CITY, TOWN	OR LOCATIO	ON			104	d. INSIDE CITY	
	MD -		Ва	1tim	ore Ci	ty		1]	YES 2 NO	
FUNERAL	106. STREET AND NUMBER			10f. 2	ZIP CODE	10g. CITIZEN OF WH			T COUNTRY?	
E	2123 Division S	Street								
5		12. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 YES 2 N	MED 13 WAS DECEMBENT OF HISPAL			17 USA ANIC ORIGIN? (Specify Yea or No			American Indian,	
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATES			elfy Cuban, Maxica ☑ X NO Specify	n, Puerlo Rican, atc.)		Black, White, etc. Specify:		
									Black	
E	15. OECEDENT'S EDUC	completed) (Gh	CEDENT'S USUAL O	during most	of working	16b. KIND OF BU	SINESS/INDU	JSTRY		
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	Do NOT use retired.)			D 1				
COMPLETED	12		Baker	-			ery			
8	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden				
BE	Unknown 194. INFORMANT'S NAME (Type/Print)					ia Ander				
2	THE POST OF THE POST OF THE PERSON OF THE PE					Route Number, City or Tow			_	
	Ruenay Hayes				_	. Balto.		2121:		
	1X) Ruriel 2 Cremeting 3 Percent from State									
	4 Donstion 5 Other (Specify) Cember (Specify) Arbutus Mem. Cem. 12/13/94 Balto, MD 21. SIGNATURE OF FUNERAL SERVICE LIGENSEE 22. NAME AND ADDRESS OF FACILITY									
	Unity Funeral Home									
_	Jr.C. 710	WW AI	1	08 W	. Nort	h Ave B	alto	, MD	21201	
	23. PART I. Enter the diseases, or co shock, or heart failure, L	omplications that caused the dealist only one cause on each line.	ath. Do not anter	r the mode	a of dying, suci	h ss cardiac or respi	ratory arre	st,	Approximata interval Batween	
	IMMEDIATE CAUSE (Final								Onset and Death	
	disease or condition a. cardiac arrhythmia									
	DUE TO (OR AS A CONSEQUENCE OF):									
Z	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):								2 years	
CERTIFICATION	if sny, lasding to immediate csuse. Enter UNDERLYING									
5	CAUSE (Disesse or injury C.	DUE TO (OR AS A CONOTO	VIEWOE AD							
ĒΙ	that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEO	OENCE OF):							
ら	d									
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
S	dilated cardio myopathy with severely depressed PERFORMED?								MPLETION OF CAUSE	
	left Ventricular function								DEATH?	
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
Ž	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
Sic		HOSPITAL: 1 Inpetient 2 ER/Outpetient 3	DOA 4 Nur		55 Rasidence	6 Other (Specify)				
Ě	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED WORK?							
BY	1 X Natural 5 Pending 2 Accident Investigation	1 X Natural 5 Pending								
	3 Suicide 6 Could not be	26a. PLACE OF INJURY — At hon building, atc. (Specify)		261. LOCATION (Street and Number or Rural Route Number,						
1	4 Nomicide determined City or Town, State)								1	
7	29a. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(a) and manner as stated.									
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
	29b. SIGNATURE AND TITLE OF CERTIFIER	m .			29c. LICENSE NUN				orith, Day, Year)	
H	Jenne X	Han P.		Ι.	8917	0.3.5.77		1-13-		
유	30. NAME AND ADDRESS OF PERSON WHO	COMBI ETED CALIFE OF DEATH (ITEM	107 (7 0/-4		07-1			, ,	1 1	

c/o Maryland General Hospital

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Leonardo Gan Lim, M.D. c/o Mary

ALEST HAR SEVERY

DEC1 4 1994

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BALTIMORE, MARYLAND 21215-0020

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTA	AL HYGIENE
CERTIFICATE OF DEATH	BEG NO

	1 - STATE OF MAR		MENT OF HEALTH AND	MENTAL HYGIENI REG. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF GEATH		3. TIME OF DEATH			
	HOWARD EDWARD AND	ERSON Jr.		Dec. 12	1994	2:30 A M			
		GE (In yrs. last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRTH	PLACE (State or Foreign			
	219-26-9731 ¹Xi м ₂ □ ғ	56 YRS. "	ONTHE DAYS HOURS MIN.	(Month, Day, Year) 6-20-19	938 Md.				
	9a. FACILITY NAME (If not institution, give street and number)	1	Db. CITY, TOWN OR LOCATION OF D		9c. COUNTY OF DI				
OR	3419 Elliott St.		Baltimore C:	itv					
5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY								
DIRECTOR		10c. CITY,	TOWN OR LOCATION			10d. INSIDE CITY LIMITS?			
	Md. Baltimore		10f. ZIP CODE			1 TES 2 NO			
FUNERAL	3701 Old North Point R	d	21222		10g. CITIZEN OF W	HAT COUNTRY?			
N.	11. MARITAL STATUS 12. WAS DECEDENT EVI		13. WAS DECENDENT OF HISPAI		USA				
	1 Never Married 2 Married FORCES? 1 X Y	ES 2 NO	If yea, specify Cuben, Mexico	in, Puerlo Ricen, etc.)	Black	— American Indian, , White, atc.			
ВУ	3 Wildowed 4 Divorced	N DATES	T TES 2 M NO Specifi	γ:	Specif	White			
COMPLETED	1s. DECEOENT'S EDUCATION (Specify only highest grade completed)	16a. DECEOENT'S US	BUAL OCCUPATION k done during most of working	16b. KIND OF BUS	INESS/INDUSTRY				
9	Elamentary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use	retired.)						
M P	12	Shippi	ng Foreman		de Stee	1			
	17. FATHER'S NAME (First, Middle, Last) Howard E. Anderson Sr.			ME (First, Middle, Maiden S					
R	19e. INFORMANT'S NAME (Type/Print)	401 14411 1110 4	MIII OF	ed Odetta					
임	Jeffrey Anderson		Old North Po			21222 ore Md			
		20b. PLACE AND DATE OF			ATION — City or Tox				
	1 N Buriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify)	Oak Lawn	Cemetery)	ltimore				
ı	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FA	CILITY					
	anthony Colt C	onnelly,	Connelly Fr 7110 Solle	uneral Hors Pt. Rd	me of D . 212	undalk 22			
	23. PART I. Entar tha diseases or complications that cau ahock, or haert fallure. List only one cause o	sed the daath. Do lot	antar tha moda of dying, auc	h as cardiac or reapin	atory arrest,	Approximata			
	IMMEDIATE CAUSE (Final	il each ilia.				Intarval Between Onset and Death			
	disease or condition resulting in death)		ier						
ľ	DUE TO (OR A	AS A CONSEQUENCE OF):							
CERTIFICATION	Sequentially list conditions, b. OUE TO (OR A	S A CONSEQUENCE OF):							
AT	cause. Enter UNDERLYING								
Ĕ	thet untated events	S A CONSEQUENCE OF):							
ERI	resulting in deeth) LAST								
	PART il. Other significant conditions contributing to deet	h but not resulting in	the underlying cause given in	Part i. 24s. WAS AN A	urmoney 24h	WERE AUTOPSY FINDINGS			
PHYSICIAN: MEDICAL			the underlying couse given in	PERFORM	NEO?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
				1 TES 2	V /	OF DEATH?			
2	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH YES	□ NO □ UNCERTAII			1 YES 2 NO			
Y	25. WAS CASE REFERRED TO MEDICAL	28. PLACE OF DEATH		101					
SIC	EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/C		THER:	6 Other (Specify)					
美	27. MANNER OF DEATH 28s. OATE OF INJUI	RY 28b. TIME (OF 28c. INJURY AT	26d. DESCRIBE HOW IN	JURY OCCURED				
BY	1 Natural 5 Pending Investigation	.,	M 1 YES 2 NO			- 1			
	3 Suicide 28a, PLACE OF INJU	. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify)			26t. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
E I									
COMPLETED	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my ki								
S I	2 MEDICAL EXAMINER: On the basis of examina	ition and/or investigation,	In my opinion, death occured at the	time, data and placa, and	due to the cause(s)	and manner as stated.			
BE (296. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUI	IBER	29d. DATE SIGNED	(Month, Day, Year)			
2	(pr miner D34210 12/15/64								
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S S	D IIII	74411	arvelle	611				
1	DEC1 41994 Jaly Davidson R			ı					
- 14	ALAMANAN TONIA LICE	Wolf.							

Item1,g-718,12-14-94,perf.h.,dr

		FOR	
1		STATE	
	_	REGISTRAR	

	1 - STATE REGISTRAR	STATE OF M					IEALTH AND DEATH	MEN	ITAL HYGIENI	E		
	1. DECEDENT'S NAME (First, Middle, Last) JOHN BE	ANON-	Brannor					_ N	EC. 9,	Y	YEAR 94	3. TIME OF DEATH 11:20 AM
DIRECTOR	4. SOCIAL SECURITY NUMBER 5.		6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6.4 YRS. MONTHS DAYS HOURS MIN.			7. 0	7. DATE OF BIRTH (Month, Day, Year) MAR . 2, 1930		6. BIRTH	PLACE (State or Foreign		
	9e. FACILITY NAME (If not institution, give street				9b. CITY,	TOWN (OR LOCATION OF I	_	,	9c. COUNTY OF DEATH		
	201 N.BROADWAY S	APT.	#5-L	BA	LT1	MORE C	CIT	TY n/a				
IRE	MADAL AND		10c. CITY, TOWN OR LOCATION							10d. INSIDE CITY LIMITS?		
	MARYLAND n/	a	BALTIMORE 101. ZIP CODE						10a CIT		1)(X) YES 2 □ NO	
BHENKERAL	201 N. BROADWAY ST	REET	APT.# 5-L 21231					UNI		STATES		
	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 [IF YES, GIVE WI	IT EVER IN U.S. ARMED YES 2 THO WAR OR DATES 13. WAS DECENDENT OF HISPANIC If yes, specify Cuben, Mexicen, if 1 YES 2 NO Specify			cen, Pu	, Puarto Rican, etc.) Black,			- American Indien, White, atc.		
<u> </u>	15. DECEDENT'S EDUCATI (Specify only highest grade con		16e.	16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working								
COMPLETE	Elementary/Secondary (0-12)		iffe. Do NOT use retired.) LABORER CONSTRUCTION) N			
COM	17. FATHER'S NAME (First, Middle, Last)			ENDON	16. MOTHER'S NAME (First, Middle, Maiden Surneme)							
BE C	SAMUEL BRANNO 190. INFORMANT'S NAME (Type/Print)	<u>N</u>				MARTHA THOMPSON						
5	GENEVA BRANNON			910	ADDRESS N		nd Number or Rure. DERIA		Number, City or Town			MD 21205
	20e. METHOD OF DISPOSITION 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removal	from State		CE AND DATE	OF DISPOSI						City or Tov	
	4 Donetton 5 Other (Specify) BALTIMORE CEMETERY 12+16 BALTIMORE, MD											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH1101 E. NORTH AE.										AE.	
PHYSICIAN: MEDICAL CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as Cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) a. Hyperbusive arterioselerate Cardiavascular disease a. Hyperbusive arterioselerate Cardiavascular disease b. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): c. Due to (or as a consequence of): c. Due to (or as a consequence of): c. Due to (or as a consequence of):											
	Dialettes mellitic Carcinous of the throat, post operation 1 yes 2 1 NO OF								WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
CIA	25. WAS CASE REFERRED TO MEDICAL			LACE OF DEAT	H (Check o	nly one)	OTTOLKIA		-			
ISA		1XXES 2 NO 1 Inpatient 2 ER/Outpetlant 3 DOA 4 Nursing Home SX Residence 8 Other (Specify)										
	1 🔀 Natural 5 🗌 Pending	5 Pending (Month, Day, Year) INJURY WORK?										
TED BY	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, of building, stc. (Specify)					ry, office	281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)					
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the ceuse(s) end menner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data end place, and due to the ceuse(s) and menner as stated.											
B	296 SIGNATURE AND TITLE OF CERTIFIER Would J. Wright MD						29c. LICENSE NUMBER O. C. M. E 29d. DATE SIGNED (Month, Day, You) ▶ DEC. 10, 199					Month, Day, Year)
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201											
	31. DATE FILED (Month On 1994) 1994	32. PEGETRA	S SIGNATURE	Handell								

Marie Land Sermit, Pages 1, 2, 3 should

BALTIMORE, MARYLAND 212 5-00-6 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attend TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

3 □•=1 3

nours after death, Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 TAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760,

permit.

IN THE BACKHAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit page 1.2 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

PHYSICIAN: MEDICAL

BY

BE COMPLETED

0

	D.N.5					94	37164
	1 - STATE OF MAR'		RTMENT OF I		MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Lest) JAMAHL KEVIN BO	NAMWC			2. DATE OF DEATH	2 9°4°	3. TIME OF DEATH 7:20 A _M
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AC 220 – 94 – 4594 1 XX M 2 🗆 F	GE (In yrs. lest birthday 23 vrs.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JAN. 15, 1		THPLACE (State or Foreign
TOR	9e. FACILITY NAME (If not institution, give street and number) 1800BLK. HENNEMAN STREE'	Г		OR LOCATION OF OR MORE CI		9c. COUNTY OF	oeath n/a
DIRECTOR	100. STATE 10b. COUNTY MARYLAND n/a	10c. C	TY, TOWN OR LOCA				10d. INSIDE CITY LIMITS? 1 X YES 2 NO
FUNERAL	3007 BELAIR ROAD	<u>'</u>		1. ZIP CODE 21213		109. CITIZEN OF	WHAT COUNTRY? STATES
ВҰ	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVE FORCES? 1 V VI IF YES, GIVE WAR OF	ES 2V NO	II yes, sp	CENDENT OF HISPAN Decity Cuben, Mexical B 2XXNO Specify	IIC ORIGIN? (Specify Yes n, Puerto Rican, etc.)	Bla	CE — American Indian, ck, White, etc.
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2 YEARS	16a, DECEDENT' (Give kind of life. Do NOT) LABORE	S USUAL OCCUPATI f work done during me use retired.)	ON ost of working	HOME IN		
BE CON	17. FATHER'S NAME (First, Middle, Lest) GEARIE BOWMAN			NORMA	ME (First, Middle, Meiden BYRD	Surneme)	***
70	190. INFORMANT'S NAME (Type/Print) NORMA BOWMAN	3007	BELAI	R ROAD,	BALTIMORE	, MARYLA	
		cometery, cremetory or	G MEMO	RIAL PARK	(13-17 BA)	CATION — CITY OF	rown, State WN O MD
	Lee V. Hollan	X-	WM.	C. MARCH	FH1101		H AVENUE
	23. PART1. Enter the diseases, or complications that causehook, or heart failure. List only one cause or IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Muliple DUE TO (OR A	aach lina.					Approximata interval Batween Onset and Death
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury	S A CONSEQUENCE (
CER	d						

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH?

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) Inpatient 2 ER/Outpatient 3 DOA

OTHER: 4 Nursing Home 5 Residence Char (Specify) INSIDE

280. DATE OF INJURY
Fall Spirit (Day, Year)
17-12-94 28b. TIME OF INJURY 5 Pending Investigation 0720 M 8 Could not be determined

28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Subject SheL 1 YES 2 NO

28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) Slyect

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)
1 300 WK Hennaman St Henn

29d. DATE SIGNED (Month, Day, Year)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end manner ee stated.

MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

O.C.M.E DEC.

111 Penn Street, Baltimore, Maryland 21201

29c. LICENSE NUMBER

er Fan. Jahran Marian Maria

1 X YES 2 □ NO

27. MANNER OF DEATH

1 Netural

2 Accident

3 Sulcide

4 Homicide

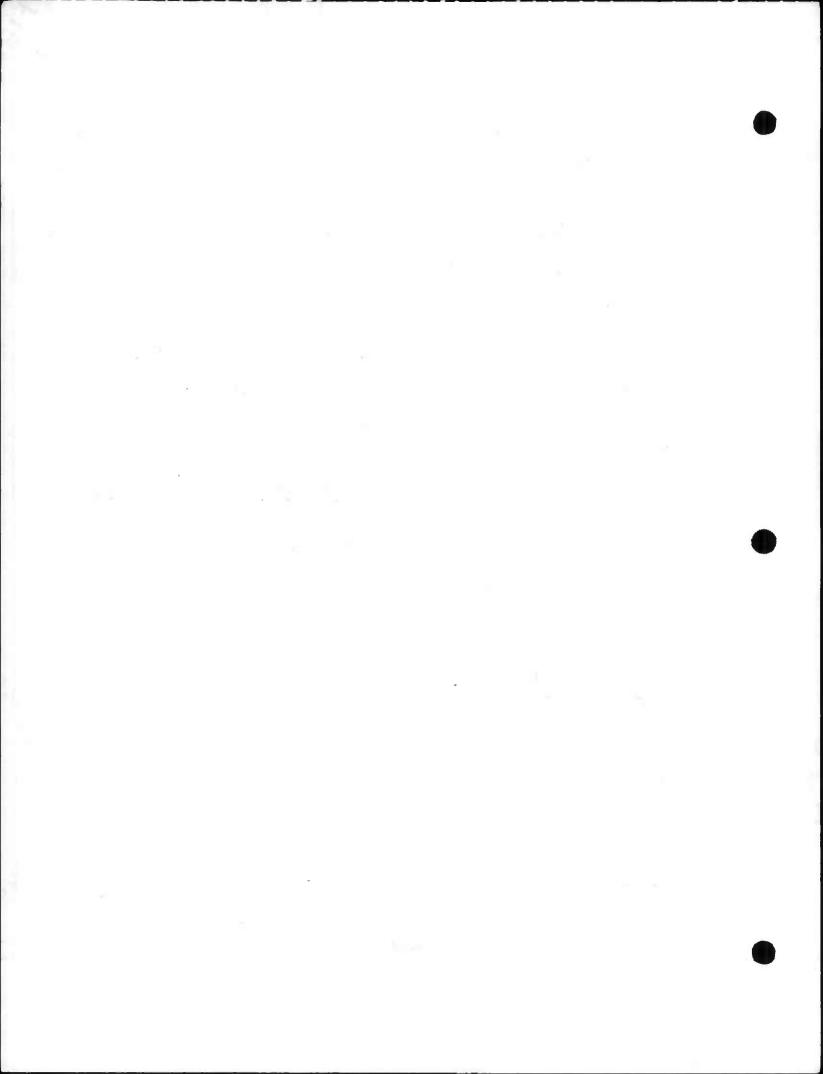
12,1994

1 YES 2 NO

14.

	5	STATE OF M	ARYLAND / [PEPARTMENT	OF HEA	ALTH AND	MENTAL	HYGIENE
Per	F.H.	Film#	G - 718	12/14/	94 F	R.M.		

		1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFICA			MENTA	L HYGIEN			
	- 1	1. DECEDENT'S NAME (First, Middle, Last)	GERALD FRA	ANCIS BER	-		2. DATE	OF DEATH		ZEAR 3.	TIME OF DEATH
		- GLAASU	F. BERAF	1			220	5MB36			6:20P.M.
P.)	4. SOCIAL SECURITY NUMBER 215-42-2188	1 X M 2 □ F	O YRS. MON	THE DAYS	IF UNDER 24 HRS. HOURS MIN.	Mos	of BIRTH h, Day, Year) th 28,	1944	Country)	y land
2, 3 should	OR	9a. FACILITY NAME (If not institution, give st Good SAMARIT	1 1			timore	EATH		9c. COUNTY		
-	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, TO	WN OR LOCAT	TION				10	d. INSIDE CITY
permit. Pages		Md Bol	timore		ARKV	ille				1 [LIMITS?
isi	FUNERAL	15 CEDARBURG	COURT A	APT C	101	1. ZIP CODE 2123	4			N OF WHA	T COUNTRY?
21215-0020 all or attending physician. for use as the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 XNO	If yes, sp	CENDENT OF HISPAN pecify Cuban, Maxica 5 2 NO Specifi	n, Puerto		s or No — 14	Black, W Specify:	
r attend use as	ED	15. OECEDENT'S EDUC (Specify only highest grade	ATION	16a. DECEDENT'S USU	AL OCCUPATION	ON	166	. KIND OF BU	SINESS/INDUS	Whi	16
21 al or for u	PLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work life. Do NOT use rel	ired.)	ost of working		NEWS	PAPI	ER	
YLAND by the hospit be detached at once.	COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA					
A by the bed at	BEC		N Beran,				NE		DRAS		
MARYLAND e retained by the hospit e 5 should be detached notified at once.	5	19a. INFORMANT'S NAME (Type/Print) IRENE Beran				ind Number or Rural			th, State, Zip Co		287
TORE, e 6 may be ector, page must be		20a, METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo	val Irom State 20b	PLACE AND DATE OF DI Detery, Cremetory or other to UNES	SPOSITION (Ne	ome of	12/g		CATION - CH	y or Town,	Stata
ALTIMOF leath. Page 6 m funeral director, xaminer musi		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	uit Pinesi	22. NAME AP	ND ADDRESS OF FA	CILITY		GELWOO	10, F	Ia.
0 = 0		* (Xerent (D)	Loved		පිළිදු	Chapel	RDF	6. Cal	Ho. Md	. 21	234
ed in b	İ	23. PART I. Enter the diseases, or c ahock, or heart fellure. I	omplications that caused liet only one cause on e	tha death. Do not e ach lina.	inter tha mo	da of dying, suc	h aa car	dec or reap	ratory arrest	i,	Approximate interval Between
y fille		IMMEDIATE CAUSE (Final disease or condition reaulting in death)	VINRICO	JAR A	BALKE	ma.					Onset and Death
ted withir complete ial, crema			DUE TO (OR AS A	CONSEQUENCE OF):	_						SOTTING
OX 687 be executed sician and confior to burial, traumatic er	RTIFICATION	if any, leading to immediate		CONSEQUENCE OF):	YOTA	HY					SARZ
0 5 5 5 E	FICA	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente	DUE TO (OR AS A								
요 트로프 등	ш	resulting In deeth) LAST	.	-							
the death y the attend of Memtal H	AL C	PART ii. Other significent conditions	contributing to death b	ut not resulting in th	e underlylng	g ceuse given in	Pert i.	24a. WAS AN		24b. WE	RE AUTOPSY FINDINGS
	MEDICA		EARCTION			1.50 SPA 100 L. SPA		PERFOR		CO	ULABLE PRIOR TO MPLETION OF CAUSE DEATH?
RECOR v requires that been signed by it, of Heafth and shows any		WITH RIGHT									YES 2 NO
AL has b Dept.	PHYSICIAN:	DID TOBACCO USE CONTR		PF DEATH YES 26. PLACE OF DEATH (C		UNCERTAIN	ИП				
	SIC	EXAMINER? 1 YES 2 NO	HOSPITAL:	OT	HER:	e 5 🗆 Residence	8 Othe	r (Specify)			
OF V PHYSICIA this certif with the rked, or		27. MANNER OF OEATH t X Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJ WO	URY AT			NJURY OCCUR	ED	
ON O DING PHYS After this death with	ВУ	2 Accident Investigation	28a. PLACE OF INJURY	— At home, lerm, street		YES 2 NO	281 LOC	ATION (Street)	and Number or i	Rumi Bouts	Number
28 I after	ETED	3 Suicide & Could not be determined	building, etc. (Spec	city)				or Town, State)		nurer mode	Namoes,
7 72 =	COMPLETED		EIAN: To the beat of my knowl t: On the beals of examination							ause(a) en	d menner as stated.
TO THE HOSPITA TO THE FUNERA Be filed within ? IMPORTANT: 1	BE (29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUN			29d. DATE SI	IGNED (Mo	nth, Day, Year)
2 2 3 2	2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, Print)	045771	0		720	.10	1994
		Ormis Impro	Sid Shot	LOCH RE	AVIN	BLVO.	BA	mile	or M	ARY	PEGIS
		31. DATE FILED (Month, Day, Year) DFC 1 4 1994	32, REGISTRAR'S SIGN	ATURE					1		



BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ding physician.	the bunal-transit permit. Pages 1, 2, 3 should	
Flours after death. Page 6 may be retained by the hospital or atte	filled in by the funeral director, page 5 should be detached for use any, or removal.	tic event, the medical examiner must be notified at once.
The law requires that the death certificate be executed within	certificate has been signed by the attending physician and completely filled in by the funeral dir. In the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ed, or Item 23 shows any injury, or other traumatic event, th
TO THE HOSPITAL OR ATTENDING PHYSICIAN: TI	TO THE FUNERAL DIRECTOR: After this certificate be filed within 72 hours after death with the State	IMPORTANT: If Item 28 is marked, or Iter

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTME CERTIFICA	NT OF HEALTH AND TE OF DEATH	MENTAL HYGIEI				
	1. DECEDENT'S NAME (First, Middle, Last)	- PEARL	Beale		2. DATE OF DEATH MONTH DECEMBER	190	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 579-03-7947	10 M 2 X F 76	YRS. WONTE	DER 1 YEAR IF UNDER 24 HRS. IS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	1	BIRTHPLACE (State or Foreign Country)		
TOR	98. FACILITY NAME (If not institution, give structure) ST. ALAS HOSA RESIDENCE OF DECEDENT		9b. C	BALL MORE	DEATH	9c. COUNTY	OF DEATH		
DIRECTOR	100. STATE 10b. COUNTY MARY AND BAY	imore		N OR LOCATION			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	100. STREET AND NUMBER 609 M. DOLLOS	1,101,100		10f. ZIP CODE	1	U.	S-A.		
В	11. MARITAL STATUS 1 Never Married 2 Married SE Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2.K NO	13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 NO Speci	an, Puerto Rican, etc.)	ns or No.— 14.	RACE — American Indian, Black, White, etc. Specify:		
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	Cation completed) College (1-4 or 5+)	16a. DECEDENT'S USUAI (Give kind of work do life. Do NOT use retire	ne durina most of workina	16b. KIND OF BU	JSINESS/INDUST	TRY		
OM	17. FATHER'S NAME (First, Middle, Lest)		MI HOW	16. MOTHER'S N	AME (First, Middle, Maide	n Surname)			
BE o	Unknown				unknown)			
2	198. (NFORMANT'S NAME (Type/Print) FRACE & R. BS A	5	1 1	ESS (Street and Number or Rural	01 00	wn, State, Zip Coo	21057		
	20a. METHOD OF DISPOSITION		PLACE AND DATE OF DISI		DATE 200. LO	OCATION — City	or Town, State		
	Burial 2 ☐ Cremation 3 ☐ Ramo Donation 5 ☐ Other (Specify)	- A GF	ROUS OF F	ALLA HTIA	1 19-10 R	COSLOAL	L. MARYLAND		
	21. SIGNATURE OF FUNERAL SERVICE LICE	200		22. NAME AND ADDRESS OF F. EVALL CHAPL 8300 HARFOR	OF PLMOR	ARKVILL			
		ompileations that caused list only one cause on ea	I tha death. Do not en ach line.	ter the mode of dying, su	ch as cardisc or resp	olratory arrest	intervai Between		
	iMMEDIATE CAUSE (Final disease or condition resulting in dasth)	DUE TO (OR AS A	CONSEQUENCE OF):	mary ede	ma		Onset and Death 4 days		
LION	Sequentially list conditions, if sny, leading to immediate	Papillary Co DUE TO OR AS A	CONSEQUENCE OF):	thyroid g	land with	netast	ases 2 years		
CERTIFICATION	csuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		CONSEQUENCE OF):						
CER	-								
PHYSICIAN: MEDICAL	PART II. Other algorificant conditions	contributing to death be		underlying cause given in	Part i. 24a. WAS AI PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
. M	DID TOBACCO USE CONTR	BUTE TO CAUSE O	F DEATH YES	NO 17 LINCERTAL			1 YES 2 NO		
CIAI	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEATH (Che	ck only one)					
14SI	1 TYES 2 TNO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outp		lursing Home 5 Residence					
BY P	1 Netural 5 Pending	(Month, Day, Year)	INJURY M	WORK?	26d. DEŞCRIBE HOW	INJURY OCCURI	ED		
	2 Accident investigation 3 Suicide 6 Could not be determined	28e. PLACE OF INJURY building, etc. (Speci	— At home, farm, street, ify)	actory, offica	28f. LOCATION (Street City or Town, State	and Number or F	Rural Route Number,		
COMPLETED				a time, data and place, end du y opinion, death occurad at the			use(a) end manner as stated.		
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	Rlande	M.D.	29c. LICENSE NU		29d. DATE SIG	GNED (Month, Day, Year)		
F	R. PANDE , ST	AGNES F	HOSPITAL	, BALTIN	TORE, I	MD 21	228		
	31. DATE FILED (Month, Day, Year) DF C 1 4 1004								

W m the state of the s

DIVISION OF VITAL RECORDS, P.O. BOX 68760

HE HOS HE FUN Fed with	SPITAL (VERAL D hin 72 ho	MRECTOR Jurs after		is certiff ith the	HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	death	ORTANT: it Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
OR ATTENDING P DIRECTOR: After t hours after death Item 28 is mari			ith the		N: The	icate ha	State De	Item 2
OR ATTENDING P DIRECTOR: After t hours after death Item 28 is mari			IYSICIAN: The is certificate ha ith the State Did. or Item 2	N: The icate has State D.	aw regu	is been	ept. of !	23 short
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

	REGISTRAR		CERTIFICAT	E OF DEATH	RE	G. NO.			
	t. DECEDENT'S NAME (First, Middle, Last)	Barksdale			2. DATE OF DE	ATH		3. TIME OF DEATH	
	WALTER	BARTS	DALE		MONTH / Z_ ~	13-	YEAR 94	900 P M	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs.	last birthday) IF UNDE	R 1 YEAR F UNDER 24 HRS.	7. DATE OF BIF	RTH	-	PLACE (State or Foreign	
	213-09-1575-4	12M2 0 F 94	YRS. MONTHS	DAYS HOURS MIN.	(Month, Day, 3-23-		Country	"VA	
	9e. FACILITY NAME (If not institution, give s	street end number)	9b. CIT	Y, TOWN OR LOCATION OF D	DEATH	9c. COL	JNTY OF D	EATH	
DIRECTOR	1807 E. 31 th	57		BALT					
E C	10a. STATE 10b. COUNT	Y	10c. CITY, TOWN	OR LOCATION				10d, INSIDE CITY	
DIR	MD		BA	LT				LIMITS?	
FUNERAL	1807 E 31 54	ST		101. ZIP CODE		1000	TIZEN OF W	HAT COUNTRY?	
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S.	ARMED 13.	WAS DECENDENT OF HISPA	ANIC ORIGIN? (Spe			- American Indian,	
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES 2	MO	If yes, specify Cuben, Mexic 1 YES 2 NO Spec	en, Puerto Rican,		Biack	White, etc.	
	15. DECEDENT'S EDU (Specify only highest grade		DECEDENT'S USUAL C	OCCUPATION	16b. KIND	OF BUSINESS/IN		DENCE	
Щ	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of work done life. Do NOT use retired.)		0	, , ,		,	
COMPLETED	(2)		LAGOR		K	iLR	UAC	3	
8	17. FATHER'S NAME (First, Middle, Last) Edgar BART	m- 111-			AME (First, Middle,		~		
BE	19e. INFORMANT'S NAME (Type/Print)		10h MAII INC ADDRES	S (Street and Number or Rural					
유	DIANE BOO	KER		S (Street and Number of Rural				21206	
	20e. METHOD OF DISPOSITION 1 Description 2 Cremetion 3 Rem	20b.PLAC	CE AND DATE OF DISPO	SITION (Name of	DATE	20c. LOCATION -	- City or To	wn, State	
	4 Donellon 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIG	wo	cremetory or other plece			Buch	. 10		
- ()	21. SIGNATURE OF FORENAL SERVICE LIN			. NAME AND ADDRESS OF F			22.1	2/2/3	
	1 ac - section	020		129 N. C				t mo	
		List only one ceuse on each li	lne.	r the mode of dying, su	ch aa cerdiac o	r reapiratory as	rest,	Approximate Intervel Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death)									
	resulting in death)	DUE TO (OR AS A CONS	SEQUENCE OF):		·			SAME	
Z	Sequantially list conditions,	b							
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONS	SEQUENCE OF):						
E I	CAUSE (Disease or Injury that Initiated avanta	c DUE TO (OR AS A CONS	SEOUENCE OF:						
E	reaulting in death) LAST		282707 55.					İ	
8		0							
DICAL	PART II. Other algnificent condition	is contributing to death but no	t resulting in the u	ndariying causa givan ir	Part I. 24a.	WAS AN AUTOPSY PERFORMED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
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Σ	DID 700 4000 4400				_			1 YES 2 NO	
AN	DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE TO CA	USE OF DEA		OPI				
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¥	27. MANNER DF DEATH	1 Inpatient 2 ER/Outpatient 28e. DATE OF INJURY	28b. TIME OF	rsing Home 5 Thesidence		HOW INJURY OC	CHIDED		
	1 Natural 5 Pending	(Month, Day, Year)	INJURY M	WORK?	and begoinse		CONED		
ВУ	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY At	home, term, street, fed			(Street and Numbe	er or Rural P	oute Number,	
COMPLETED	4 Homicide determined	building, atc. (Specify)			City or Town	n, State)			
PE	290. CERTIFIER (Check only 1 CERTIFYING PHYSI	ICIAN: To the best of my knowledge,	death occurred at the	time, date end place, and du	e to the cause(s)	and manner as ats	ited.		
NO.	anal —	ER: On the beele of exemination end/						end manner ee stated.	
w II	29b. SIGNATURE AND TITLE OF CERTIFIE	R		29c. LICENSE NU	JMBER	29d. DA	TE SIGNED	(Month, Day, Year)	
0	David	Silver T	20,	H 432	34	D I	ECE	MBER 14, 1994	
5	30. NAME AND ADDRESS OF PERSON WH	27AH						- 11	
	2 3 2 3	ORLEANS	SST	BALTIM	ORE,	MD:	2/2	24	
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE POSPITAL OF ATTENDING PHYSICIAN. The Lew requires that the death certificate be executed with burns after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be made within the State Door, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANY II IMM 28 is marked, or less 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE

DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or injury that initiated events or injury that injury	REGISTRAR		CERTIF	FICATE (OF DEATH		REG. NO.			
212-05-1476 Image: Common Secti			CO	х		2. DATE MONT	Dec 5	1994	YEAR 3	TIME OF DEATH
Townson Town	4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	SE (In yrs. last birthday)	IF UNDER 1 YE	EAR IF UNDER 24 HR	s. 7. DATE	OF BIRTN		8. BIRTNPL	ACE (State or Engalon
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Surdia Carameten Recording Recordi	JOHN W. COX, JR	•	156	ORANGI	E COURT E	ALTIM	ORE, MI	0. 212	234	
RCCK TOWSON FURERAL HOME INC. 1050 YORK ROAD TOWSON, MD. 21204 23. PART I. Enter the diseases. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Set Onset and incertain disease or condition. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OP): Sequentially list conditions, If any, leading to immediate cause. Enter UNDEFLYING that Initiated events resulting in death) DUE TO (OR AS A CONSEQUENCE OP): DUE TO (OR AS A CONSEQUENCE OP): DUE TO (OR AS A CONSEQUENCE OP): The cause. Enter UNDEFLY INC. DUE TO (OR AS A CONSEQUENCE OP): DUE TO (OR AS A CONSEQUENCE OP): The cause. Enter UNDEFLY INC. DUE TO (OR AS A CONSEQUENCE OP): SMALL BOWEL OBSTRUCTION DUE TO (OR AS A CONSEQUENCE OP): The cause of the consequence of the consequence op: SMALL BOWEL OBSTRUCTION DUE TO (OR AS A CONSEQUENCE OP): The cause of the consequence op: The consequence op: DUE TO (OR AS A CONSEQUENCE OP): The consequence op: DUE TO (OR AS A CONSEQUENCE OP): The consequence op: DUE TO (OR AS A CONSEQUENCE OP): The consequence op: DUE TO (OR AS A CONSEQUENCE OP): The consequence op: DUE TO (OR AS A CONSEQUENCE OP): The consequence op: DUE TO (OR AS A CONSEQUENCE OP): DUE TO (OR AS A CONSEQUENCE OP): DUE TO (OR AS A CONSEQUENCE OP): The consequence op: DUE TO (OR AS A CONSEQUENCE OP)	1 X Burlel 2 □ Cremetion 3 □ R									
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30. NAME AND ADDRESS OF PERSON WND COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ERLANDO ROMERO, MD ST. JOSEPH MEDICAL CENTER TOWSON, MD 21204	(Check only									nd manner se atsted.
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	30. NAME AND ADDRESS OF PERSON ERLANDO ROME	WND COMPLETED CAUSE DE I	DSEPH MED	o, Print)			VD 2120	04	-+	ATT
	31. DAY ELER (MONTH PRO 1007)	Jaly Davelor R								

ITEMS: 23 PART I, 27, PER MEO FILM G-719 1/9/95 t.t

		REGISTRAR		CERTIF	ICATE O	F DEATH		REG. NO.						
		1. DECEDENT'S NAME (First, Middle, Last)	DADNEN				2. DATE	OF DEATH	Y Y	EAR 3.	TIME OF DEATH			
		NICOLE	DABNEY				DEC				0631 A M			
		4. SOCIAL SECURITY NUMBER	125	(In yrs. lest birthday)	IF UNDER 1 YEAR		7. DATE	OF BIRTH		Country)	CE (Stete or Foreign			
₽		Infant	1 M 2 💢 F	YRS.	MONTHS 1 DAYS	HOUNG MIN.	11,	21/94	£	Ba1t	0., MD			
3 should			99. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL E.R. BALTIMORE CITY											
2, 3	CTOR	SINAI HOSPITAI	E.R.		BALT	IMORE C	ITY	1						
	5	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	,	40a CIX	Y, TOWN OR LOC	2471041				1				
20	DIRE	Maryland	•		altimo						I. INSIDE CITY LIMITS?			
permit. Pages		10e. STREET AND NUMBER				10f. ZIP CODE			40- 0171751		XVES 2 NO			
1St	FUNERAL	4520 Pimlico	Road			21215				SA	COUNTRY?			
020 physician. burial-transit	5	11. MARITAL STATUS	12. WAS DECEDENT EVER II FORCES? 1 YES	N U.S. ARMED	13. WAS D	ECENDENT OF HISPAI specify Cuben, Maxico	NIC ORIGI	17 (Specify Yes	or No— 14	. RACE - Black, W	American Indien,			
	₽	Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	ATES	1 🗆 Y	ES 24 NO Specif	y:	rican, etc.)		Specify:	Black			
215-0 r attending use as the	유	15. DECEDENT'S EDUC (Specify only highest grade		16a. DECEDENT'S	USUAL OCCUPAT	TION	168	. KIND OF BUS	INESS/INDUS	TRY				
2 de la companya de l	4	Elamentary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT u	work done during i se retired.)	most of working								
O g B	MPLET	n/a			n/a				n/a					
d 0 0 E	8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First,	Middle, Meiden S	Sumeme)					
\$ \$ 6 Z	BE (Franklin Dabne	e y			Saund	ra E	Battle	į					
MA retain 5 sho	10	190. INFORMANT'S NAME (Type/Print) Franklin Dabne)	Y			co Road					21215			
Pag by		20e. METHOD OF DISPOSITION 1 Duriel 2 Cremetion 3 Rem	20b	PLACE AND DATE	OF DISPOSITION /	Name of	DAT		ATION — City					
E ect o		4 Donetign 6 Other (Specify)	K	netery, crematory or o	orial	Park	12/1	4 Ran	dall:	stow	n, MD			
		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	01		Y O. DY		C SON	EIIM	PDAT	HOME			
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ES after on by the removal.		23. PAST L. Enter the diseases or o	omplications that caus	the death. Do	not antar the n	noda of dying, auc	h as can	diac or respir	atory arrea	NUE	Approximate			
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CLAN: ertific the St	YSI	XX YES 2 NO	HOSPITAL:		4 - Nursing Ho	ome 5 - Residence	6 🗆 Othe	r (Specify)						
O	PHY	27. MANNER OF DEATH 1)(2) Natural 5 Pending	26s. DATE OF INJURY (Month, Day, Year)	26b, TIM IN,	JURY V	NJURY AT WORK?	26d. DE	CRIBE HOW IN	JURY OCCUR	ED				
DING PHYS After this death with	B	2 Accident Investigation Investigation												
TTENDII A		3 Suicide 6 Could not be determined 26e. PLACE OF INJURY — At home, farm, atreet, fectory, office building, etc. (Specify) 26e. PLACE OF INJURY — At home, farm, atreet, fectory, office building, etc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)												
DR ATTEN DIRECTOR: Yours after Item 28 is	ETE	4 Hornicide Determined					<u> </u>							
	교	29e. CERTIFIER (Check only 1 CERTIFYING PHYSIC	CIAN: To the best of my know	ledge, death occurr	ed at the time, de	nte end place, end due	to the car	use(s) end menr	ner as stated.					
HOSPITAL FUNERAL WITHIN 72	COMPL	one) 2 XMEDICAL EXAMINE	R: On the besis of examination	n end/or investigation	on, in my opinion,	, death occured at the	time, date	end place, end	due to the c	euse(s) en	d manner es stated.			
TO THE HOSPITAL TO THE FUNERAL be filed within 72 important: If	E	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUI					nth, Day, Year)			
THE Fled	8	Wonald Huhin	HMD			O.C.M					0,1994			
F F 7 €	임	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type	, Print)	2.0								
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			32. REBISTRAR'S SIGN											
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32. DEGISTRAR'S SIGNATURE Jelin Skudeon Randell

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH ZAMES 2MIN WAC R DEC 94 02:52 A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. OATE OF BIRTN (Month, Day, Year IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 1 M 2 | F HOURS 65 Caro-YRS. 249-40-8549 27 South 1 ina 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR North West Medical Center **Baltimore** RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD **Baltimore** 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 3510 Sedgemoor Road 21207 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—I1 yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WANT OR DATES 1 Never Married 2 Married 2 NO BY Specify: 3 Widowed 4 Divorced **Black** ETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12th Military Career Man U.S. Army (4) 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) F David D. Dawkins Inez 8 notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 0 Geraldine Dawkins 3510 Sedgemoor Rd. Balto. Md. 21207 pe 20s. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Buriel 2 Cremetion 3 Removal from State 4 Donation G Other (Specify) Garrison Forest Vet. 12/19/94 Owings Mills, Md examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME, INC 4600 Liberty Hights Ave. Balto. Md 23. PART I Enter the diseases, or complications that couled the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest 2120 Approximate medical IMMEDIATE CAUSE (Final Onset and Death the disease or condition_ recuiting in death) LUNG CANCER event. JUKNOWN DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING other t CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST 0 Injury, PART II. Other significent conditions contributing to death but not reculting in the underlying cause given in Pert i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24s. WAS AN AUTOPSY any 1 TES 2 NO OF DEATN? shows : 1 TYES 2 7 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL Item ? 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL OTHER: 1 YES 2 NO 1 Impatient 2 ER/Outpatient 3 DOA Nursing Home 5 - Residence 6 - Other (Specify) ò 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, INJURY Natural 1 YES 2 ND BY 2 Accident Investigation 28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number City or Town, State) 6 Could not be COMPLETED 200 4 Homicide Item 29s. CERTIFIER

1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL D BE filed within 72 ho 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29h. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Ker D43960 12/14/94 0 36. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

OLD COVET Rd. BALTIMORE



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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687604

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and most lead to the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once.

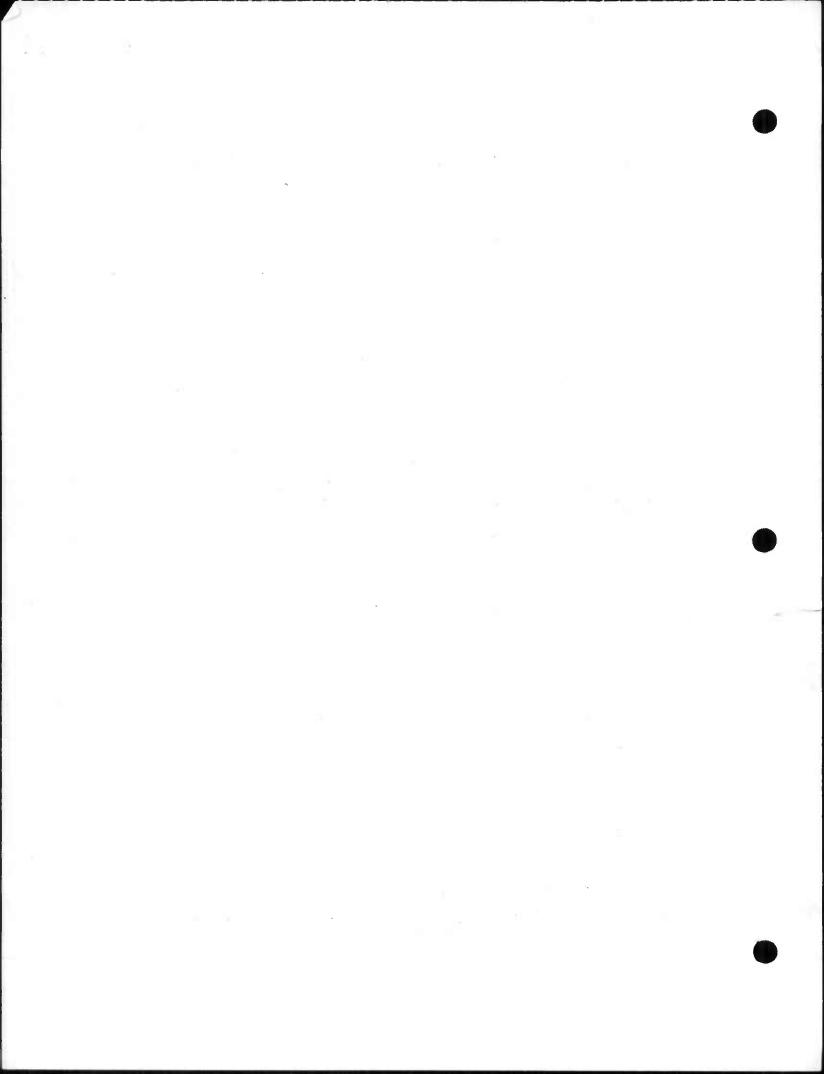
FOR STATE

	REGISTRAR		CERTIF	CATE OF	DEATH	REG. N	0.		
	t. DECEDENT'S NAME (First, Middle, Last)	alone Dan				2. DATE OF DEATH MONTH	DAY Y	3. TIME OF DEATH	
	Virginia Ma					DECEMBER	12 190	14 14 m	
	010 50 1010		(In yrs. lest birthday) 44 vns.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) NOV . 10, 1		BIRTHPLACE (State or Foreign Country) LORIDA	
œ	9a. FACILITY NAME (If not institution, give street Union Memorial		,		OR LOCATION OF DI		9c. COUNTY	OF DEATH	
DIRECTOR	RESIDENCE OF DECEDENT	nospita	7	Balt	more C:	Lty	n	/a	
Ä	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCA	1.7			10d. INSIDE CITY	
	MARYLAND	n/a		BALTIN				LIMITS? VES 2 NO	
VERAL	10e. STREET AND NUMBER 2619 LLEWELYN			10	1. ZIP CODE 21213		UNITE	D STATES	
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 VES IF YES, GIVE WAR OR	2 VINO	13. WAS DE	CENDENT OF HISPAR Beelfy Quban, Maxica S 2 1 NO Specifi	NC ORIGIN? (Specify Y n, Puerto Rican, etc.) /:	as or No 14.	RACE — American Indian, Black, White, etc. Specify:BLACK	
	15. DECEDENT'S EDUCA (Specify only highest grade co		16a. DECEDENT'S	USUAL OCCUPATI ork done during m	ON ost of working	16b. KIND OF B	USINESS/INDUST	ГЯУ	
COMPLETED	Elamentary/Secondary (0-12)	College (1-4 or 5+) YEARS	COOK	retired.)	or working	REST	AURANT		
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BE C	EDWARD DAVIS				VERA				
10	JEROME A. CHA	PMAN	196. MAILING 2619	AOORESS (Street LLWELY	N AVEN	Poute Number City or To UE, BALTII	Wn, State, Zip Co.	MARYLAND # 13	
	20e. METHOD OF DISPOSITION 1 Courted 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	al from State 20	b. PLACE AND DATE Of the VOSHELL	F DISPOSITION (A	ame of	OATE 20c. L	OCATION — City		
	21. SIGNATURE OF FUNERAL SERVICE LICEN		403UETT	7	NO ADDRESS OF FA		DUNDALK	, MARYLAND	
	· deev. 3	Iollane		WM. (. MARCH	FH1101	E. NOR	TH AVENUE	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
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CERTIFICATION	Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
FICA	Cause. Entar UNDERLYING CAUSE (Disease or Injury Unit initiated events DUE TO (OR AS A CONSEQUENCE OF):								
E	reaulting in death) LAST								
	PART II. Other algnificant conditions	contributing to death	but not resulting in	tha underlyin	g causa given in	Part I 24a WAS A	N AUTOPSY	24b. WERE AUTOPSY FINGINGS	
MEDICAL				, , , , , , , , , , , , , , , , , , , ,	g g	PERFC	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
MED							2/10	OF DEATH?	
ä	DID TOBACCO USE CONTRI	BUTE TO CAUSE (OF DEATH YE	NO E	UNCERTAIN	1 □			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL:	26. PLACE OF DEAT	Check only one;					
14S	1 YES 2 NO 1	Inpetiant 2 ER/Out	patient 3 DOA	4 - Nursing Hor	ne 5 🗆 Raaldenca		III II III 000 III		
	1 Natural 5 Pending	(Month, Day, Year)	INJU	IRY W	PRK? YES 2 NO	28d. DEŞCRIBE HOW	INJURY OCCUR	1	
D BY	3 Suicide 6 Could not be	26s. PLACE OF INJUR building, etc. (Spe	Y — At home, term, st	reet, factory, offic	•	281. LOCATION (Street		Bural Route Number,	
IE	4 Homicide determined	January, etc. (Sp.				City or Town, State	9)		
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL CONTROL OF								
8	MEDICAL EXAMINER:	On the besis of examination	on and/or investigation	, in my opinion, o	leath occured at the	time, data and piaca, a	nd due to the ca	use(s) and manner as stated.	
	296. SKINATMBY AND TITLE OF GERDIFIER				29c. LICENSE NUN	IBER	29d. DATE SIG	GNED (Month, Day, Year)	
BE	11/20 /6 11	6. PEL	1-1		ATAUR	C9111	10	12.94	
TO BE	30. NAME AND ADDRIESS OF PERSON WHO C	COMPLETED CAUSE OF DE	EATH (ITEM 27) (Type.	Print)	AT243	8946	1 /2	12.94	
ω	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DI MORIAL 32_REGISTRAR'S SIGN	Hospi		AT243	8946 niversity	► /2 PKuy.	Balto, Md.	

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the float has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYL		ENT OF HEALTH AND TE OF DEATH	MENTAL HYGIEI				
	1. DECEDENT'S NAME (First, Middle, Lest)	D mullu	VFF		2. DATE OF OEATH MONTH	1994 YE	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 316 24 6881 9a. FACILITY NAME (If not institution, give	1 - M 2 X F 8	O YRS. MONT		7. DATE OF BIRTH (Month, Day, Year)	714 10	BIRTHPLACE (State or Foreign Country)		
CTOR	1 6	RETTSVILLE	ROAD	FORST HILL	DEATH	HAR			
- DIRECTOR		RFORO		OREST HILL			10d. INSIDE CITY LIMITS? 1 YES 2 NO		
FUNERAL	100. STREET AND NUMBER BEAST JARRET 11. MARITAL STATUS	12. WAS DECEDENT EVER I	AO	10f. ZIP CODE	0	V.	S.A.		
BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 YES	2 NO	13. WAS DECENDENT OF HISP/ If yes, specify Cuban, Mark 1 — YES 2. NO Speci	en, Puerto Rican, atc.)		RACE — American Indian, Black, White, atc. Specify:		
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		life. Do NOT use retin	one during most of working od.)	16b. KIND OF BU	JSINESS/INDUST	RY		
OMP	12 YRS		MI	18. MOTHER'S N	AME (First, Middle, Maidei	n Surnamel			
BE C	HERRY LU	Hum		0	YRITS	ALZAH	ck		
TO B	19e. INFORMANT'S NAME (Type/Print)			NESS (Street and Number or Rura	Route Number, City or Tox	vn, State, Zip Coc	17349		
-	KOCERT H. DUF	F	BOX331 1	54 BONDSTRI	ST NEWF		1 15m.		
	20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)		PLACE AND DATE OF DIS netery, cremetory or other ple		19-13 B11	OCATION — City	9-0-4		
	21. SIGNATURE OF FUNERAL SERVICE U			22. NAME AND ADDRESS OF F EVANS FUNCE 2 (15)	ACILITY	Bu Ri	1ARYLAND 2, P.A. 21050 1JL MARYLAND		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approxima									
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	· acut	MI				Interval Batween Onset and Death		
_	_	ASCL	CONSEQUENCE OF):				Jyrs		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):	11.7			Dune		
N S	cause. Enter UNDERLYING CAUSE (Disesse or Injury	c. DULC	CONSEQUENCE OF:	lletus			10gms		
E	thet initieted events reaulting in death) LAST	d	onocoochoc or y.						
	PART II. Other algolificent condition	ne contributing to deeth h	ut not regulting in the	underlylan agus alvan k	Part I. 24s. WAS AF	. autronov T	A4. WEEDS ALEXANDER		
CAL	and any any and any any any any any any any any any any		at not recuting in the	condeniging cedes given in	PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
PHYSICIAN: MEDIC					1 TES	228, NO	OF DEATH?		
ž	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YES	NO D UNCERTA	IN 🗆				
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		IER:					
HYS	1 ☐ YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Outp	28b. TIME OF	Nursing Home 5 Residence 28c. INJURY AT	6 Other (Specify) 28d. DESCRIBE HOW	INJURY OCCUR	ED.		
ВУ Р	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WORK? 1 YES 2 ND					
- 1	3 Suicide 8 Could not be 4 Homicide daterminad	28e. PLACE OF INJURY building, etc. (Speci	— At home, farm, street,	factory, office	281. LOCATION (Street City or Town, State	end Number or R	lural Route Number,		
COMPLETED	CONDON ONLY	SICIAN: To the best of my knowl ER: On the basis of examination			, ,		use(a) and manner ee stated.		
BE C	296. SIGNATURE AND TITLE OF CEATIFIE	M		29c. LICENSE NU	IMBER	29d. DATE SIG	GNED (Month, Day, Year)		
0 B	NI.			D34	052	120	12 1994		
-	30. NAME AND ADDRESS OF PERSON WE	O COMPLETED CAUSE OF DE		71 0 = 0	LAIR M	001			
	31. DATE FILED (Month, Day, Year)	A Sensible State	NEAGE OF	HAVE. B	THIR!	HRYLA	UD		
	DEC1 41984	1 June man							



OR STATE BEGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
EDENT'S NAME (First, Middle, Last)		2 DATE OF DEATH

		1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPAR CERTIF	TMENT OF I	HEALTH AND MI	ENTAL HYGIE			
	9	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH			TIME OF OEATH
			dalen	FAJMA	N	100	ecember	9, 1994	YEAR]	10:15 P M
-	10	4. SOCIAL SECURITY NUMBER 212-10-3732		yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN	Month, Day, Year)		Mary1	ce (State or Foreign
3 should		9e. FACILITY NAME (If not institution, give str	reet end number)		9b. CITY, TOWN	OR LOCATION OF DEAT			TY OF DEATH	
8	DIRECTOR	Franklin Square	Hospital]	Baltimore		Balt:	imore	
Jes 1,	EG	10e. STATE 10b. COUNTY		10c. CIT	r, TOWN OR LOCA	TION			10d	I. INSIDE CITY
r. Pag	듬	Maryland B.	altimore		Ва	1timore			1.5	LIMITS?
Deca	IAL	10e. STREET AND NUMBER			10	H. ZIP CODE		10g. CITIZE	EN OF WHAT	COUNTRY?
an. ransit	FUNERAL	9 Paula Place,				21237		τ	J.S.A.	
BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physician. ye furneral director, page 5 should be detached for use as the burial-transit permit. Pages moval. Ical examiner must be notified at once.	BY FU	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 XNO	If yes, sp	CENDENT OF HISPANIC Decify Cuben, Mexican, S 2 X NO Specify:		lee or No— 1	14. RACE — A Black, Wh Specify: Wh	American Indian, nile, etc.
215 attend	8	15. DECEDENT'S EDUC (Specify only highest grade of	ATION	18e. DECEDENT'S	USUAL OCCUPATION OF COMPANY	ON	16b. KIND OF B	USINESS/INDU		
21: tal or for u	9	Elementary/Secondary (0-12)	Coffege (1-4 or 5+)	Iffe. Do NOT us	e retired.)	ost or working				
-AND the hospi detached	COMPLETED	10 17. FATHER'S NAME (First, Middle, Last)		Home	maker			vn Home	1	
YLA by the be def		Conrad Minder:	lein			18. MOTHER'S NAME		en Surmerne) Lsch		
MARN e retained t 5 should 1	BE	19e. INFORMANT'S NAME (Type/Print)	Te III	19b. MAILING	ADDRESS (Street a	and Number or Rural Rou			Codel	
M, e reta	임	Joan McCurdy				ar Rd., Ba			1236	
BALTIMORE, er death. Page 6 may be the funeral director, page val.		20a, METHOD OF DISPOSITION 11 ABurlel 2 Cremetion 3 Remo 4 Donation 6 Other (Specify)	val from State 20b. F	LACE AND DATE O	of oisposition (Na her place) Redeeme			OCATION — CI		
Page al dire		21. SIGNATURE OF FUNERAL SERVICE LICE		St HOLY	22. NAME A	ND ADORESS OF FACIL				ryland
death		· Eugene	V. Cirl	206		munek Fune Belair Rd				236
B after s after by th emova		23. PART I. Enter the diseases, or co	phiplications that coused	the dae in Do n	ot anter the mo	oda of dylng, such a	na cardiac or rea	piratory erre	et,	Approximate
P.O. BOX 68760, BALTIMORE, h cartificate be executed within 24 hours after death. Page 6 may be anding physician and completely filled in by the funeral director, page Hygbers prior to burial, cernation, or removal. or other traumatic event, the medical examiner must be		IMMEDIATE CAUSE (Fine) disease or condition resulting in dath)	Ist only one cause on eac Uroseps							Onset and Daeth 5 days
760 ad with omple st. crea			OUE TO (OR AS A C	CONSEQUENCE OF	7:					
K 68760, executed within and completely to bunal, cremamatic event,	NOI	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	ONSEQUENCE OF						
BO) ate be prior r trau	CAT	cause. Enter UNDERLYING CAUSE (Disease or injury								
DS, P.O. BOX 68760 he death certificate be executed with the attending physician and comple Mental Hygiene prior to burial. crel nijury, or other traumatic even	CERTIFICATION	that initiated eventa reaulting in death) LAST	OUE TO (OR AS A C	CONSEQUENCE OF	7:					
S, e deat he att Menta Jury,		PART II. Other algnificent conditions	contributing to death but	not regulting i	n the underlyle	a cause alves in De	mt 1 04- 1100 4	N. A. PRODOV	I are sugg	
R at the and by In	CAL	Cardiomyopa	athy	not readiting t	ii the dilderlyin	a cause diven in ha	PERF	ORMED?	AVAI	RE AUTOPSY FINDINGS ILABLE PRIOR TO APLETION OF CAUSE
RECOR requires that een signed b of Health ar shows any	MEDICA	Coronary ar	tery disease	Conges	stive he	art failu	_ 1 Tes	2 NO	OF E	DEATH?
A requestrated been been been st. of sthe		DID TOBACCO USE CONTR				UNCERTAIN	-		'-	TES 2 NO
TAL The law te has b site Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	20		H (Check only one)					
F VITA SICIAN: The certificate h the State (YSIC	1 TYES 2 NO	HOSPITAL: 1 Inpatient 2 - ER/Outpat	lent 3 🗆 DOA	OTHER: 4 Nursing Hom	ne 5 🗆 Residence 8	Other (Specify)			
OF VITAL RECO PHYSICIAN: The law requires th this certificate has been signed with the State Dept. of Health riked, or litem 23 shows an	РНҮ	27. MANNER OF DEATH 1 N Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	26b. TIMI INJ	URY WO	DRK?	8d. DESCRIBE HOW	INJURY OCCU	RED	
ON OI HING PHYS After this death with	BY	2 Accident Investigation	28a PLACE OF IN HIDY	At home form of		YES 2 NO	A4 1 00171011 (0)		2	
DIVISION OR ATENDING F THEODR: After the death The B is mar	ED	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY – building, etc. (Specify	- At nome, term, s	treet, factory, offic	2	8f. LOCATION (Street City or Town, State		' Rural Route	Number,
0 5	<u>F</u> .		IAN: To the best of my knowled							
(R	i o	one) 2 MEDICAL EXAMINER	: On the beele of exemination	end/or investigatio	n, in my opinion, d	leath occured at the tim	ne, date end place,	and due to the	cause(e) and	menner ee stated.
	BE	290. SIGNATURE AND TITLE OF CENTIESER	San	~	Com	29s. LICENSE NUMBE	EM	29d. DATE S	SIGNED (Mon	nth, Day, Year)
₽ ₽ ₽ ≥ ≥	2	30. NAME AND ADDRESS OF PERSON WHO		'H (ITEM 27) (Туре,	Print)			1		
4		Dr Boon Lim MD 900	0 Franklin So	quare Dr	ive Bal	timore Man	ryland 2	1237		
		DEC1 4 1994 Jul	32, REGISTRAR'S SIGNAT	URE						
		- 0								

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

	1 - FOR STATE OF MARYLAND / DI REGISTRAR CER	EPARTMENT OF HEA		ITAL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)			DATE OF DEATH		3. TIME OF DEATH	
	JACKSON HOFFA FRANTZ			cember 11	1994	08:45 A M	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest bir		UNDER 24 HRS. 7. E	ATE OF BIRTH	6. BIRTH	IPLACE (State or Foreign	
3	711-07-6406 12M2DF 76	YRS. MONTHS DAYS H	OURS MIN.	Month, Day, Year)	18 IEL	ISBURG, PA.	
	9e. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR L	OCATION OF DEATH				
DIRECTOR	GREATER BALTIMORE MEDICAL CENTER	TOWSON			BALTI	MORE	
EC	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10	DC. CITY, TOWN OR LOCATION				10d. INSIDE CITY	
DIA	MARYLAND BALTIMORE CO.	COCKEYSUIL	LE			LIMITS?	
AL	10e. STREET AND NUMBER		CODE	10	g. CITIZEN OF V	VHAT COUNTRY?	
FUNERAL	10315 APT. K MALCOLM, CIR.		11030		U.S	3.A.	
J.	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Ves 2 NO		ENT OF HISPANIC OF	RIGIN? (Specify Yee or larto Ricen, etc.)	No- 14. RACE	— American Indian, s, White, etc.	
В	3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES	1 - YES 2		, , , , , , , , ,	Speci		
ED	. 15. DECEDENT'S EDUCATION 16a. DECED	PENT'S USUAL OCCUPATION		16b. KIND OF BUSINE	SS/INDUSTRY	VHIO	
Ē.	(Specify only highest grade completed) (Give k Elementary/Secondary (0-12) College (1-4 or 5 +)	ind of work done during most of NOT use retired.)	0				
MPL	12 2 CIV	11L ENGINE	ER				
COMPLET	17. FATHER'S NAME (First, Middle, Last)	16	MOTHER'S NAME (F	irst, Middle, Maiden Surr	name)		
B	JASPER PRAINTE		RUTH	HOFFA			
2	194 INFORMANT'S NAME (Type (Print)	AlLING ADDRESS (Street and)	V An A.I. A.I.	Number City or Town, St	mm, Elp Code)	1.1.16	
	208 METHOD OF DISPOSITION	DATE OF DISPOSITION (Name)	N MITTE	um cik.	COCKY.	SVILLE, MP.	
	1 If Burlal 2 □ Cremation 3 □ Removal from State compley_compley	WATER EM -	1	2-15 LEININ	CR + D /	PA. UNION CO.	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND	DORESS OF FACILITY	201 0	1000	PIJ. CITATAL CO.	
	rethen I have made	EVAN	TUND	KAL CT	noNIUI	m m	
\neg	23. PARTA. Enter the diseases, Dr compilertions that caused the death.	. Do not antar the mode	of dying, auch aa			Approximate	
	immediate cause (Final				,	Interval Batween Onset and Daath	
j	disease or condition resulting in death)					48 lus	
Ì	DUE TO (OR AS A CONSEQUE					1/0 / 0	
Z	Sequentially list conditions,					48 W	
ATK	if any, leading to immediate cause. Enter UNDERLYING	NCE OF):				7 Sauce	
FIC	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUE)	NCE OF):				1 day	
CERTIFICATION	resulting in death) LAST					!	
	PART II. Other algorificant conditions contributing to death but not reau	iting in the underbalance	una aluma in Au				
CAL	12 Earles	iting in the underlying ca	use given in Part	PERFORMED	0?	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
EDI	10.000			1 🗆 YES 2 🗙	NO	OF DEATH?	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH	YES I NO M	JNCERTAIN [, `		1 TYES 2 NO	
AN	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF	F DEATH (Check only one)	JINCERIAIN L	-			
SIC	EXAMINER? 1 YES 2 NO 1 Anpatient 2 ER/Outpatient 3 I	OTHER:	☐ Residence 6 ☐	Other (Specify)			
	(Month, Day, Year)	b. TIME OF 28c. INJURY WORK?		DESCRIBE HOW INJU	RY OCCURED		
ВУ	1 Natural 5 Pending 2 Accident Investigation		2 NO				
	3 Suicide 6 Could not be 4 Homicide determined	farm, atreet, fectory, office	261.	LOCATION (Street and I City or Town, State)	Number or Rural R	loute Number,	
COMPLETED							
린	29a. CERTIFIER (Check only one) One)						
S I	One) 2 MEDICAL EXAMINER: On the beele of exemination end/or investigation	itigation, in my opinion, death	occured at the time,	date end piece, and du	e to the ceuse(s) and manner ee stated.	
BE (29b. SIGNATURE AND THAT OF CERTIFIER	29	LICENSE NUMBER	29	d. DATE SIGNED	(Month, Day, Year)	
2	30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH WITH	A / None Primer	N37788	'	12-11	77	
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) DOWN'S ROBERTS, KIED., 6565 N. CVI	wher St. Six	c405, 13.	elto, Mid.	. 2120	+	
ŀ	31. DATE FILED (Month, Day, Year) DEC1 4 1994						

ACC 20 10 10

201 - 20

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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within and not set of the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or them 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAD STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR			ENTIF	ICALE	: Ur	DEAL	П	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Le Fred Fu	rell, SF							2. DATE OF DEATH MONTH DA		YEAR 3	TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 226-05-375	5. SEX	6. AGE (In yrs. Ia:		IF UNDER MONTHS	1 YEAR DAYS	IF UNDER 2		7. DATE OF BIRTH (Month) 2. Year) 12-12-12		Country)	ACE (State or Foreign
	9e. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH						тн	
DIRECTOR	VA MEDICAL C	ENTER			BA	LTI	MORE	CI	TY			
問	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10e							Dd. INSIDE CITY				
	MD			I	BALTIMORE CITY					1 X YES 2 NO		
FUNERAL	100. STREET AND NUMBER 517 WILLOW AVE				101. ZIP CODE 2.1.2.1.2.			U.S.A.				
3	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AF	RMED	13. \	MAS DEC	ENDENT OF	HISPANI	C ORIGIN? (Specify Yes			- American Indian, Yhite, etc.
	1 Never Married 2 Merried	IF YES, GIVE V	YES 2 THE PAR OR DATES	NO			ecify Cuban, 2 X NO		, Puerto Rican, atc.)		Black, V Specify:	Vhite, etc.
MINIT T							ACK					
COMPLETED	15. DECEDENT'S E (Specify only highest gro	DUCATION ide completed)	16e. D6	ECEOENT'S	USUAL OC	CUPATIO	ON st of working		16b. KIND OF BUS	INESS/INDUS	TRY	
9	Elementary/Secondary (0-12)	College (1-4 or 5	He iiie				st of working					
₩ I				OIL	ER				LOUIS	DRUF	USS	co.
8	17. FATHER'S NAME (First, Middle, Last)								E (First, Middle, Maiden	Surneme)		
BE		TRELL					HENR	IET	TA	GRAN'	T	
2	190. INFORMANT'S NAME (Type/Print)								oute Number, City or Town			
	MARY FUTRELL		5	17	WILL	OW	AVE	BAL	TIMORE,	MD.	2121	. 2
	20e. METHOD OF DISPOSITION 1 Burlel 2 □ Cremetion 3 □ Re	emoval from Stata	20b. PLACE cemetery, cre			TION /Ne	me of		OATE 20c. LOC	ATION - CIT	y or Town	, State
	1 Buriel 2 Cremetion 3 Re 4 Donetion 5 Other (Specify)		GARRI	SON	FOR				12/16 OW	INGS	MII	LS, MD.
	21. SIGNADIME OF PUNERAL SERVICE	LICENSEE			22. 1	NAME AN	D ADDRESS	S OF FACI		TOTTATEO	DAT	HOME
	* Helly	Cron	raite	2)	11	29	N. C	ARO	BETTS LINE ST.	BAL	TO, M	
	23. PART I Enter the dispuses, of ahock, or heart fallur	r complications the	t caused the de	eath. Do r	not enter	the mo	da of dyln	g, such	as cardiac or respir	atory arres	it,	Approximata
	IMMEDIATE CAUSE (Final	c. List only one cat										Interval Between Onset and Death
	disease or condition resulting in death)	. 1	sophai	real	. 1	CAN	(81/	•				10mos
		DUE TO	(OR AS A CONSE	QUENCE OF	F):			•				
Z	Sequentially list conditions,	ь										
CERTIFICATION	if any, leading to immediate	DUE TO	(OR AS A CONSE	OUENCE OF	ገ ፡							
5	CAUSE (Disease or Injury	C										
E	that initiated events resulting in death) LAST	DUE 10	(OR AS A CONSE	OUENCE OF	F):							i
5		d										
	PART II. Other significant conditi	ons contributing to	death but not i	resulting	in the un	deriying	cauae gi	ven in P	art I. 24a. WAS AN		24b. W	ERE AUTOPSY FINDINGS
EDICAL							1000		PERFOR	/		MILABLE PRIOR TO OMPLETION OF CAUSE
									1 YES 2	XNO		F DEATH?
Σ	DID TOBACCO USE	CONTRIBUTE	TO CALL	SE OF	DEAT	u v	EC 17	NO		'	1	TYES 2 NO
A	25. WAS CASE REFERRED TO MEDICAL	T	- 10 CAO	JL OI	DLAI		ACE OF DE		LJ J			
PHYSICIAN:	EXAMINER?	HOSPITAL:	ED/Outputtent 6		OTHER	1:						
¥ I	27. MANNER OF OEATH	26e. DATE OF	ER/Outpetient 3	28b. TIM		28c. INJ		-	Other (Specify) 28d. OESCRIBE HOW IN	IIII OCCUI	BEO	·
	Netural 5 Pending	(Month, D		INJ	URY	WO	RK?		Tod. OLGONIDE NOW III	0000	NEO	
B	2 Accident Investigatio	28e. PLACE O	F INJURY — At he	ome, ferm, s	street, facto			-	281. LOCATION (Street or	nd Number or	Rumi Bou	to Number
COMPLETED	4 Homicide 6 Could not to	building,	atc. (Specify)	7.5					City or Town, State)	TVD///Dor Or	rioral riog	is Nonze,
91	29a. CERTIFIER		- 20 20 1			1,,,,,,,,,			les come les			
₽ P									the cause(s) and man			
8			kamination eng/or	Investigatio	n, in my o	pinion, d	eath occured	d at the ti	me, date end place, end	due to the o	ceuse(s) e	nd menner ee stated.
8	296. SIGNATURE AND TITLE OF CERTIF	MA A					29c. LICEN	ISE NUME	DER	29d. DATE S	BIGNED (M	onth, Day, Year)
임	30. NAME AND ADDRESS OF PERSON	VHO COMPLETEO CAU	SE OF OEATH (ITE	M 27) (Type	Print)		10	4	4	- 1/	4/1.	-174
	BVAMC.	- Dr.	N. Cl	mist	line	1	e	ر ر				
	DEC1 4 199	32. REGISTRA	R'S SIGNATURE	D	,							
	0101410	7		Labore	6							

STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR HERMAN FLOYD EMBER 1994 DEC 11:40 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 5. SEX 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 215-40-7736 1 🔀 M 2 🗌 F YRS. 53 07-31-41 BALTIMORE 9e. FACILITY NAME (If not institution, give street end number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RESIDENCE OF DECEDENT RECTOR Pages 1, 2, 3 BALTIMORE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY ō permit. 1 MD BALTIMORE 1 TYES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? use as the burial-transit 1518 RIGGS AVE. 21217 usa Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 If yee, specify Cuben, Mexicen, Puerto Rican, etc.)

1 VES 2 NO Specify: FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried ВУ Specify: BLACK 3 Widowed 4 Divorced ED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b, KIND OF BUSINESS/INDUSTRY (Specify only highest grade COMPLET the attending physician and completely filled in by the funeral director, page 5 should be detached for Mental Hygiene prior to burial, cremation, or removal. Elementary/Secondary (0-12) College (1-4 or 5+) 12th CLERK-HARDWARE STORE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) CODY FLOYD 10 JEANETTE CHESLEY BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 ESTHER MURRAY 744 RESERVOIR ST. BALTO. MD. 21217 Pe 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1X Burlel 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) MT: ZION CEMETERY 12-13-94 LANSDOWNE MD. examiner 21. SIGNATURE OF FUNERAL SENGGE LICENSES 22. NAME AND ADDRESS OF FACILITY hours after death. ALBERT P. WYLIE F/H PA 638 N. GILMOR ST. 21217 medicai 23. FART I. Enter the diseases, or complications that ceused the daeth. Do not anter the mode of dying, such as cardiec or respiratory erreat, Approximate shock, or heart failure. Liet only one cause on each line. Interval Between IMMEDIATE CAUSE (Fine) **Onset and Death** the disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease event. DIVISION OF VITAL RECORDS, P.O. BOX 68760, Chronic Obstructive Pulmonary Disease traumatic CERTIFICATION Sequentielly liet conditiona, If any, leading to immediate cause. Enter UNDERLYING - Diabetes Mellitus CAUSE (Disease or Injury thet initiated events resulting in death) LAST any injury. PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO signed by t Health and COMPLETION OF CAUSE 1 YES 27 NO OF DEATH? 1 TYES XIX NO this certificate has been with the State Dept. of PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: OR ATTENDING PHYSICIAN: XYES 2 NO 1 | Inpatient 2 | ER/Outpetient 3 | DOA 4 - Nursing Home XXResidence 8 - Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked (Month, Day, Year) t X Natural 5 Pending 1 YES 2 NO BY After death 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify) after de 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined COMPLETED DIRECTOR: 4 Homicide THE FUNERAL DIRECT filed within 72 hours a IPORTANT: If Item 2 1 CERTIFYING PHYSICIAN. To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end manner ee attated. SPITAL 2 XMEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(e) end manner es steted. MPORTANT AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE DECEMBER O.C.M.E. 9 13. 1994 ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LARON LOCKE

M D

32 REGISTRAR'S SIGNATURE

31. DATE FILED (Mont

4 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DHMH-15 Rev 1/89

111 Penn Street, Baltimore, Maryland 21201

	1. DECEDENT'S NAME (First, Middle, Las						2. DATE	OF DEATH	MY	YEAR	3. TIME OF DEATH
- 1	-James, Fr	buest			Guest,		12	-	7	94	5:15
- 11	4. SOCIAL SECURITY NUMBER	5. SEX 1 № M 2 □ F	6. AGE (In yrs. Ia:	THE SECTION AND ADDRESS.	IF UNDER 1 YEAR MONTHS DAYS		(Mont	OF BIRTN h, Day, Year)		Count	
- 0	217 24 0369 9e. FACILITY NAME (If not inetitution, give	1	64	YRS.				.16, 1	930	_	RYLAND
œ	VA Baltimo				CO. 1	OR LOCATION OF E			9c. COUN		
6	RESIDENCE OF DECEDENT	776			0-1411	more, M	<u></u>		D-	17	inon
DIRECTOR	10a. STATE 10b. COUN			10c. CITY,	TOWN OR LOCA	C	ern				10d. INSIDE CITY LIMITS?
	MARYLAND 100. STREET AND NUMBER	n/a			BALTIM	UKE	ern		1		1)(()(YES 2)
RAL		ILLAGE RO	۱۸۵		1	01. ZIP CODE 21144					WHAT COUNTRY?
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	Never Merried 2 Merried	FORCES? 1V	Y YES 2 1		If yes, s	s 2 NO Speci	en, Puerto		01110-	Blac	ck, White, etc.
BY	3 Widowed 4 Divorced	A	RMY		_ '''	XX	",			Spac	BLACK
TED	15. DECEDENT'S EI (Specify only highest gre		(G	live kind of wo	ISUAL OCCUPAT ork done during rr	TION nost of working		. KIND OF BU			
PLET	Elementary/Secondary (0-12)	College (1-4 or 5 +		. Do NOT use	,			NITED	STA		(
*	HIGHSCHOOL 17. FATNER'S NAME (First, Middle, Leat)			<u>ABORE</u>	R	40 440774704044	_	RMED		VICE	S (ARMY)
雄		SR.				18. MOTNER'S N		Middle, Maiden	Surneme)		
BE	19e. INFORMANT'S NAME (Type/Print)	JK.	19	b. MAILING /	ADDRESS (Street	end Number or Rural	ELLE	her City or Tow	vn State Zin	Code	
임	FARZER HATCHER					ILLAGE, S			RYLANI		21144
	20e. METHOD OF DISPOSITION		20b. PLACE	AND DATE OF	F DISPOSITION (A		DAT		CATION -		
	X Buriel 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emovel from State	CROWN	SVILL	E VA	CEMETERY	Y 12	- 15 0	CROWNS	SVIL	LE, MD
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	2		22. NAME /	AND ADDRESS OF F	ACILITY				
	tice Vis	Bolla	nd		WM.	C. MARCH	FH	1101	E. NO	ORTH	AVENUE
			e on each ilne	b.		ode of dying, su				,	interval Be
ICATION	iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly ilst conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	с	OGST	OUENCE OF	Pulm						intervai Be
RTIFICATION	disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING	b	OBST	OUENCE OF	Pulm						interval Be
CERTIFICATION	Sequentielly ilst conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST	b	OR AS A CONSE	OUENCE OF)	- Pulm	onery Di	: 30-3				interval Be
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC			MENTAL	HYGIEN REG. NO		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH		3. TIME OF DEATH
	WALTER		GREEN,	II	[Dec		1994	0204
	4. SOCIAL SECURITY NUMBER 219-78-7092	5. SEX 6. AGE	0.0	UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		OF BIRTH	1974	or Foreign or Foreign
	9a. FACILITY NAME (If not institution, give str	reet and number)	98	. CITY, TOWN C	R LOCATION OF D	EATH		9c. COUNTY	OF DEATH
СТОВ	2200 blk. E. Lanvale STreet Baltimore								
DIRECTOR	Md .		10c. CITY, T	Balt	imore		10d. INSIDE CIT LIMITS? YES 2		
FUNERAL	10a. STREET AND NUMBER 908 Andover Ro		101. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D	2 NO	If yes, spi	ENDENT OF HISPAL city Cuben, Mexica 2 NO Specifi	in, Puerto P	? (Specify Yes		RACE — American Indian, Black, White, atc. Specify: Black
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary Secondary (0-12)	ATION completed) College (1-4 or 5+)	18a. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during mo- tired.)		16b.		SINESS/INDUSTI	RY
MPL	8th		Lab	orer			Wa	rehous	se
BE CO	17. FATHER'S NAME (First, Middle, Last) Walter Green	Jr.			18. MOTHER'S NA Jani	ME (First, A	diddle, Malden Jones	Sumame)	
TO B	19a. INFORMANT'S NAME (Type/Print) Janice Jones		19b. MAILING AD 908 A	ndove:	Road	Route Numb	er, City or Tow timor	n, State, Zip Code	yland 21218
	20a. METHOD OF DISPOSITION 10 US US US US US US US US US US US US US	val from State 20b	PLACE AND DATE OF D	meter	ne of 12/	12/9		cation — city of a lem,	Maryland
	21. SIGNAPURE OF FUNDRIAL SERVICE LICE	B. Cas	1		D ADDRESS OF FA	(ral Service , Md. 21215
	23. PART i. Enter the diseases, or co	mplications that caused	I tha death. Do not						Approximate
	IMMEDIATE CALISE (Fine)	. MUTPLE DUE TO (OR AS A	sch ilna.						Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
AL C	PART II. Other significant conditions	contributing to death b	ut not resulting in t	ha underlying	cause given in	Part i.	24a. WAS AN		24b. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICA						_	PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ä	DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YES	□ NO □	UNCERTAIL	N			^
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLACE OF DEATH (THER					
Ş.	1 XYES 2 NO	1 Inpatient 2 ER/Outp	atient 3 DOA 4 (Nursing Home	5 Residence				
	1 Natural 5 Pending	(Month, Day, Year)	INJURY	WOI 1 Y	IK?	Q1/2	THE OW	SHAT O	THE ALL TOWARD
) BY	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY	- At home, farm, stree	•		28f. LOCA	ATION (Street a	nd Number or Ru	iral Route Number,
Homicide determined building, etc. (Specify)						LE BALTIMORE			
COMPLETED		IAN: To the best of my knowl	edge, death occurred a	t the time, date		to the caus	se(a) and man		ina(e) and menans as sint of
	201 HOMBTURE AND TITLE OF CERTIFIER	A ()	1				and place, an		
TO BE	CHALLET SE	le An			29c. LICENSE NUI				NED (Month, Day, Year)
	MAKO = GOLLO-	JR MD	йн (ген 27) (3 ₀₀ м. это _111 Pen		et Ra	ı]+in	nore	Marul	and 21201
- 1		. HERETEN KER						-riory	

 HILL

1 - FOR STATE REGISTRAR

LILLIE

1. DECEDENT'S NAME (First, Middle, Last)

296. SIGNATURE AND TITLE OF CERTIFIER

RANJAN PAUL

31. DATE FILEO (Month, Day, Year)
DEC1 4 1994

MO

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Sa REGISTRAR'S MONATURE

Waw

BE

9

882

3 TIME OF DEATH

MD

REG NO

2. DATE OF DEATN

BALTIMORE, MARYLAND 21215-002	phys	Puri
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OR ATTENDING PHYSIONAL THE LINE requires that the death certificate be executed within a fours after death. Page 6 may be retained by the hospital or attending physical physi	6
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MAE 3.25 AMM D. Odenher 1 994 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTN (Month, Day, Year 8. BIRTHPLACE (State or Foreign DAYS 241-64-5258 1 M 2 KKF 65 DEC.25. CAROLINA N. permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN DIRECTOR Union Memorial Hospital Baltimore City n/a RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND n/a BALTIMORE 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? I-transit 1754 GORSUCH **AVENUE** 21218 UNITED STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2/ Married
3 Wildowed 4 Divorced If yes, specify Cuban, Maxican, Puerto Rican, etc.) BY 1 TES 2 NO Specify BLACK COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) DOMESTIC/HOMEMAKER 6 TH in own home 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) te **GEORGE** POWELL LILLIE JONES BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Cephus HILL SR. GORSUCH AVENUE, BALTIMORE, MARYLAND 21218 1754 9 20a. METHOD OF DISPOSITION

1 Burlal 2 Cremation 3 Removal from State 20c. LOCATION - City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must VALLEY PARK 12-16 ANNE ARUNDEL co. Donation 5 Other (Specify) MEMOR I AL examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH **AVENUE** medicai 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, auch as cerdiec or respiratory arrest, Approximate ahock, or heart feliure. List only one ceuse on each line 6 Interval Between IMMEDIATE CAUSE (Finel Onset and Death the cremation, disease or condition resulting in death) ANONE BRAIN INJURY 2 DAYS traumatic event, DUE TO (OR AS A CONSEQUENCE OF): 2 DAYS. ARREST CARDIAC CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): 9 If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury other OUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST 0 signed by the atter Health and Mental PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? Chr. RENAL FAILURE, MYPERTENSION, DIABETES MELLITUS shows any 1 YES 2 NO L Certificate has been s th the State Digit, of Hi 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{\overline{\text{VINCERTAIN}}}\) UNCERTAIN \(\Boxed{1}\) 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one, HOSPITAL: OTHER:
4 Nursing Home 5 Realdenca 6 Other (Specify) 1 YES 2 NO 1 Ninpatient 2 - ER/Outpatient 3 - DOA b 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED and) 1 Natural 1 YES 2 NO BY Affer Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office 3 Suicide 40 281. LOCATION (Street and Number or Rural Floute Number, City or Town, State) 8 Could not be COMPLETED E H 4 Homicide 28 29a. CERTIFIER 1 🔀 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER

UNION MEMORIAL ROSPITAL, 2018, UNIV PRINY, BALTIMORP, MD-21218.

T243 8946

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

OHMH-18 Rev 1/89

29d, DATE SIGNED (Month, Day, Year)

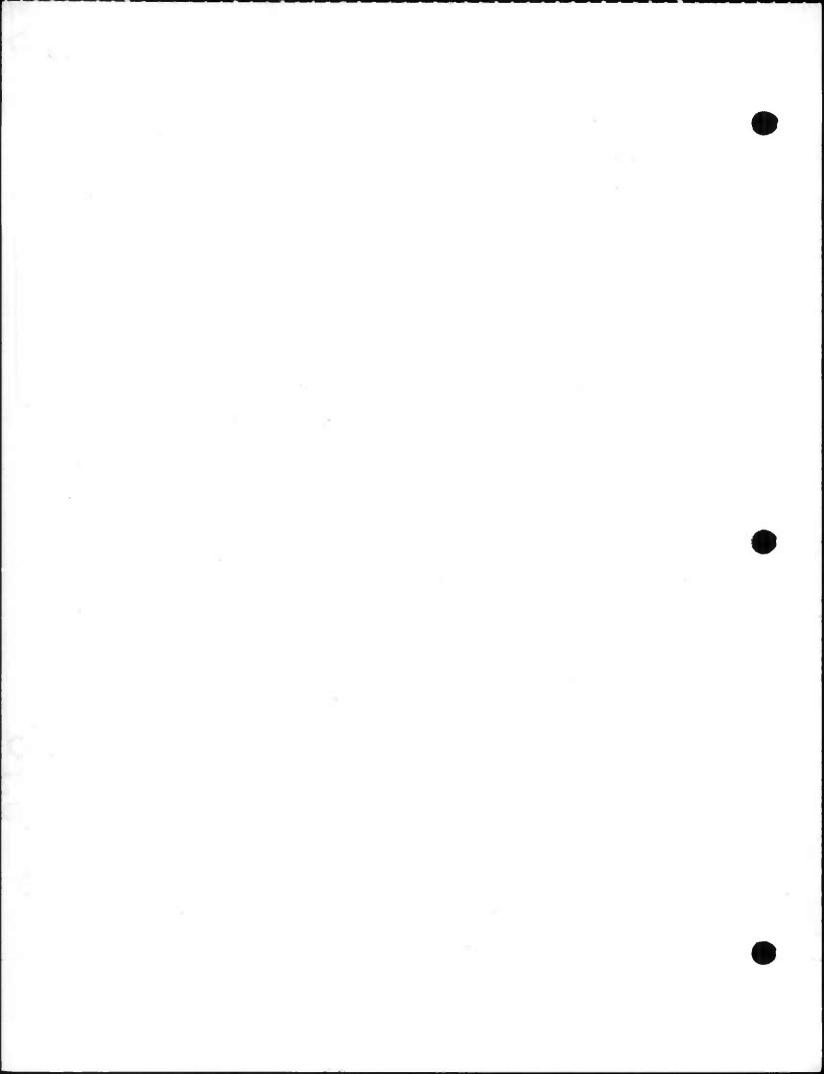
December 12, 1994.

ours after death. Page 6 may be retained by the hospital or attending physician. I in by the funeral director, page 5 should be detached for use as the burfal-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

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BALTIMORE, MARYLAND 21215	To TITENDING PHYSICIAN: The law requires that the death certificate be executed with Jours after death. Page 6 may be retained by the hospital or attend	UNIG TUPE. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as		
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	FOR STATE REGISTRAR	STATE OF MARYLAND /		T OF HEALT		MENTAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH	
	John Paul Hu	bbard				December 1	1,1994	11:00 A. M	
	4. SOCIAL SECURITY NUMBER 226-01-8919	5. SEX 6. AGE (In yrs. lest	YRS. IF UNDE	DAYS HOURS	DER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) June 10, 1	C	IRTHPLACE (State or Foreign ountry) Virginia	
	9e. FACILITY NAME (If not institution, give st	. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION (
DIRECTOR	Pickersgill Nur	sing Home		Towson			Balt	imore	
EG	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY							10d. INSIDE CITY	
PHO	Maryland Bal				e			LIMITS?	
AL	10e. STREET AND NUMBER				DDE		10g. CITIZEN	OF WHAT COUNTRY?	
FUNERAL	9009 Hedgerow W			2	1236		U.	S.A.	
E.	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER IN U.S. ARM FORCES? 1 X YES 2 NO	MED 13			IC ORIGIN? (Specify Yee , Puerto Rican, etc.)	or No- 14. F	RACE — American Indian, Black, White, etc.	
ВҰ	3 XWidowed 4 Divorced	IF YES, GIVE WAR OR DATES		1 TYES 2 X N	O Specify.			Specify: White	
	15. DECEDENT'S EDUC (Specify only highest grade		EDENT'S USUAL (OCCUPATION during most of wor	-t-/	16b. KIND OF BUS	INESS/INDUSTR		
COMPLETED	Elamentary/Secondary (0-12)	College (1-4 or 5 +)	Do NOT use retired.,		King		611		
W	12	D:	ry Clear				y Clea	ning	
	17. FATHER'S NAME (First, Middle, Last) John Paul Hubba:	rd				ME (First, Middle, Melden h Kate Cro			
B	19a. INFORMANT'S NAME (Type/Print)		MAILINO ADDRES			loute Number, City or Town			
유	George F. Neeb, II					altimore,		236	
	20a_METHOD OF DISPOSITION 1 \[\text{ABurlet} 2 \] Cremation 3 \[\text{Remo} \]	20b. PLACE AF	ND DATE OF DISPO	SITION (Name of			CATION — City of		
	4 Donation S Dther (Specify)	Everg		ial Par		12/14 Roa	noke, V	/irginia	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	/ 22 S	chimune	k Fund	eral Homes	. Inc.		
	- Cugene 1	Lastonia	5 h 9	705 Bel	air R	d., Baltim	ore, MI	21236	
CERTIFICATION	IMMEDIATE CAUSE (Final	DUE TO (OR AS A CONSEOU	Sus DENCE OF): Yence OF):					Approximate Interval Between Onset and Death	
PHYSICIAN: MEDICAL C	DID TOBACCO USE CONTR	trad of han	H YES	NO DE UN	_	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
₫	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	OF DEATH (Check						
HYS	1 YES 2 TNO	1 Inpatient 2 ER/Outpatiant 3 E	28b. TIME OF	rsing Home 5 🗆	Raaldence (3 Other (Specify) 28d. DESCRIBE HOW IN	HIPV OCCUPE		
Z	1 Natural 5 Pending	(Month, Day, Year)	INJURY M	WORK?	□ NO	200. DESCRIBE NOW IN	JUNY OCCUME	ĺ	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY — At hom building, atc. (Specify)	ne, farm, streat, tec	ctory, office		281. LOCATION (Street e City or Town, State)	nd Number or Ru	rsl Route Number,	
COMPLETED		CIAN: To the best of my knowledge, dest						se(s) and menner ee stated.	
BE O	296. SIGNATURE AND TITLE OFFICERTIERS	0.			CENSE NUM			NED (Month, Day, Year)	
2	11116	Ly		<i>D</i>	257	205	12/	12/24	
	Dr. W. Anthony Ri			Suite 2	203, T	lowson, MD	21204		
	31. DAY ELLE (4014 1994 Ju	22 REGISTRAR'S SIGNATURE							



executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician, and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

permit.

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COMPLETED

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27. MANNER OF DEATH

1 Netural

3 Suicide

29a. CERTIFIER

4 Homicide

Accident

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.60	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or r	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the me
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	execute	and co	o burial	natic (
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH YEAR Margaret Catherine Harrison 10:25 A December 12,1994 4 SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. (Month, Day, Year) 219-10-2266 DAYS HOURS 1 - M 2X F YRS Maryland 9a. FACILITY NAME (If not institution, give atreet and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATH Good Samaritan Hospital DIRECTOR Baltimore City RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore City Md. X YES 2 NO 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 803 South Eaton Street 21224 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE - American Indian, Black, White, etc. 2 NO 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 TYES 2 NO Specify Specify: BY 3 Widowed 4 Divorced White ED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complet 16b. KIND OF BUSINESS/INDUSTRY E Elementary/Secondary (0-12) College (1-4 or 5+) Meat Packing Co. COMPL Clerical 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Carl Narock Ħ Barbara Heinlein BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Clem Rt. 2 Box 411 Ridgeley, W. Va. 26753 pe 20a. METHOD OF DISPOSITION

¹X Burial 2 ☐ Cremation 3 ☐ Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 4 Donation 5 Other (Specify) Moreland Memorial Park 12-15-94 Balto.Md the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Charles S. Zeiler & Son Inc. 5 901 S. Conkling St. Balto., Md. completely filled in by the rial, cremation. or removal. 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart fellure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final **Onset and Death** EtiPlay 13th A WITH (typoxIA disease or condition resulting in death) SMOS event, DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. TO (OR AS A CONSEQUENCE OF); if any, leading to immediate cause. Enter UNDERLYING L. EG CAUSE (Disease or Injury or other t the attending physical displayed the property of the property that initiated events resulting in death) LAST injury, PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS signed by the AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 TYES 2 THO OF DEATH? 1 YES 2 NO certificate has been the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one. OTHER:

1 YES 2 NO

HASPITAL:
1 Dinpetient 2 ER/Outpetient 3 DOA

28a. DATE OF INJURY

28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify)

4 Nursing Home 5 Realdence 6 Other (Specify) 26b. TIME OF INJURY 28c. INJURY AT WORK?

26d. DESCRIBE HOW INJURY OCCURED 1 YES 2 NO 28I, LOCATION (Street and Number or Rural Route Number, City or Town, State)

12

1 D CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basi	e of examination and/or investigation, in my opin	nion, death occured at the time, data and	place, and due to the cause(a) and menner as stated
29h. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER	29d DATE SIGNED (Month Day Sharl)

- digir, ord , 738033

Investigation

determined

6 Could not be

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		1///
IRENE F. IBARRA, M.D., 100 N.BRUASWAY	W 11 "	
THE TOTAL STATE OF THE POST OF THE PASSING	BAITIMURE	ms). 2/231
31. ME FILED (Mognity, Boy, 1804) 18. REGISTRARY SIGNATURE 1994 Julia Dawolor harlell)	,
UEUI 4 1994 Julia Davaler Revolati		

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 55 hours after death. Page 6 may be retained by the hospital TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

sit permit. Pages 1, 2, 3 should

	1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG, NO.							
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH		3. TIME OF DEATH		
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	215-28-3996 1□M2XQXF 6.		UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN.	7. DATE OF BIRTH	L932 8. BIRTH	PLACE (State or Foreign Y) MD		
OR	98. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 2520 HOLLINS FERRY RD BALTO							
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	10c. CITY, TO	OWN OR LOCATION			10d. INSIDE CITY		
	MD 100. STREET AND NUMBERFerry		BALTO 101, ZIP CODE			LIMITS?		
NERA	2520 HOLLINS FETRY RD		2123		U.S.			
COMBLETED BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4XXDivorced 12. WAS DECEDENT EVER II FORCES? 1 YES II YES, GIVE WAR OR D	NUS ARMED AL NO ATES	13. WAS DECENDENT OF HISPAN If yea, specify Cuban, Maxica 1 YES 2 NO Specify	n, Puarto Rican, etc.)	or No— 14. RACE Blact Speci	E — American Indian, k, Whita, etc. fly: BLACK		
2	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USU	JAL OCCUPATION done during most of working tired.)	16b. KIND OF BUS	INESS/INDUSTRY	551.0		
ABLE	College (1-4 or 5+)	ife. Do NOT use re	tired.)	Cityryo	OF BA	LTIMORE		
S	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NA	ME (First, Middle, Maiden				
BE	CORNELIUS LEVI		DESDM					
욘	2ADA HARRIS	9709	DRESS (Street and Number or Rural F		,,	D 01160		
	20a. METHOD OF DISPOSITION 20b	PLACEANDDATEGED	SLALOM RUN	DATE 20c LOC	CATION - City or To	wn Steta		
	1 X Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	RUID RIG	DE CEMETERY	121594 B	ALTO, M	D		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	\cap	22. NAME AND ADDRESS OF FA					
	Wille Elmon	\mathcal{V}_{-}	MARCH F/H-V			AVE		
	23. PART I. Enter the diseases, or complications that cause on a shock, or heart failure. List only one cause on a	tha daath. Do not ach lina.	anter the moda of dying, auc	h aa cardiac or reaple	ratory arreat,	Approximate Interval Between		
	IMMEDIATE CAUSE (Final disease or condition	CARRITA	0			DM M1 C-DIATE		
	disease or condition resulting in death) a. SUDDEN CARDIAL DEATH DUE TO (OR AS A CONSEQUENCE OF):							
NO	Sequentially list conditions, If any, leading to Immediate DUE TO (OR AS A CONSEQUENCE OF):							
CERTIFICATION	If any, leading to Immadiata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evants Due to (or as a consequence of): Due to (or as a consequence of):							
TIF	that initiated evants resulting in death) LAST	CONSEQUENCE OF):	GITATION					
						17.		
CAL	PART II. Other significant conditions contributing to death b	ut not raauiting in t	he Underlying cause givan in	PERFOR	MED?	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
EDI				1 🗍 YES 2	X40	OF DEATH?		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE O	F DEATH YES	□ NO 🛛 UNCERTAIN	1 🔯		1 123 2 NO		
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF DEATH (Check only one)					
HYS	1 ☐ YES 2 NO 1 ☐ Inpetiant 2 ☐ ER/Outp 27. MANNER OF DEATH 268. DATE OF INJURY	etlant 3 DOA 4 [Nursing Home 5 Residence 26c. INJURY AT	8 Other (Specify) 28d. DESCRIBE HOW IN	HIRV OCCURED			
ВУ РІ	1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation	INJURY	WORK? M 1 YES 2 NO	ESG. DESCRIBE NOW IP	WONT OCCORED			
COMPLETED B	2 Accorden	— At home, farm, stree	t, factory, office	28f. LOCATION (Street a City or Town, State)	nd Number or Rural F	loute Number,		
'n	29a. CERTIFIER (Check only) CERTIFYING PHYSICIAN: To the best of my know	ledge, death occurred a	the time data and place and due	to the cause(s) and man	per se steled			
OMF	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination) and manner as stated.		
ш	29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUN	IBER	29d. DATE SIGNED	(Month, Day, Year)		
TO B	Jame J. Staffend 40		D 30	834	12/12	1194		
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DE			RAM	2	,		
	JAMES L. STAFFORD M.	AYURANA A	GREENE ST	BALTO, MO	2120	/		
	12 DECI 4 1994	- Shirting						

31. DATE FILED (Month, Day, Year)
DEC1 4 1984

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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	FOR 1 - STATE REGISTRAR	STATE OF MARY	(LAND / DEPARTI CERTIFIC	MENT OF HEALTI		ENTAL HYGIEN REG. NO	_	
	1. DECEDENT'S NAME (First, Middle, Last) GENEVA P.	HAIRSTON			I	2. DATE OF DEATH	°	3. TIME OF DEATH 11:00 A M
-	4. SOCIAL SECURITY NUMBER 226-36-0113			F UNDER 1 YEAR IF UND ONTHS DAYS HOURS	BARRA .	April 17,	1922 8. BIR	THPLACE (State or Foreign Intry)
TOR	9s. FACILITY NAME (If not institution, give st 1102 DRUID HILL	r		BALTIMOR			9c. COUNTY OF	DEATH
DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY	•	10c. CITY,	TOWN OR LOCATION				10d. INSIDE CITY LIMITS?
FUNERAL (100. STREET AND NUMBER 1102 Druid Hill	Avenue		10f. ZIP CO	DE			1 X YES 2 NO
BY FUNE	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 NO		an, Mexicen,	ORIGIN? (Specify Yee Puerto Rican, etc.)	Bia	ACE — American Indian, ack, White, etc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	18a. DECEDENT'S US (Give kind of wor life. Do NOT use of UNKNOWN	k done during most of world	ing	16b. KIND OF BUS	I SINESS/INDUSTRY	
	17. FATHER'S NAME (First, Middle, Last) Willie Dillard					(First, Middle, Meiden	Surneme)	
) BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AI	DDRESS (Street and Numb		t Staples ute Number, City or Tow	n, State, Zip Code)	
2	<u> Nelores</u> M. Owens	<u> </u>	3205	Brightwood	Aveni	ue Balto,	Md 2120)7
	20e, METNOD OF DISPOSITION 1 (X Burtel 2 Cremetion 3 Removal from State 4 Donation s Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetery,							
	21. SIGNATURÉ OF FUNERAL SERVICE LIC	ENSEE TO CALL	/	22. NAME AND ADDR	H Wes	s t		
N	23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Hypertensive Arteriosclerotic Cardiovascular Disease Disease							
ERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):						
ပ	PART II. Other significant conditions	s contributing to death	but not resulting in	the underlying cause	givan in Pa	ert i 24a WAS AN	AUTOPSV 2	AN WEDE AUTORSY ENDINGS
PHYSICIAN: MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. DIABETES MELLITUS 24a. WAS AN AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 — YES 2 X NO						AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
Ž Z	DID TOBACCO USE CONTR	RIBUTE TO CAUSE	OF DEATH YES	□ NO □ UN	CERTAIN	INSPE	CTION	1 TES 2 NO
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX WES 2 \(\sum \) NO	HOSPITAL:	28. PLACE OF DEATH	(Check only one) THER: Nursing Home				
	27. MANNER OF DEATN XX Natural 5 Pending	28a. DATE OF INJUR (Month, Day, Year	Y 28b. TIME C	F 28c, INJURY AT	2	Other (Specify)	NJURY OCCURED	
TED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28a. PLACE OF INJU building, etc. (S)	RY — At home, farm, stre		_	81. LOCATION (Street & City or Town, State)	and Number or Rura	I Route Number,
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSIC 2 X XEDICAL EXAMINER	CIAN: To the beet of my kno	owledge, death occurred a	nt the time, data end place	e, end due to	the cause(a) end men	ner as stated.	o(a) and menner ee stated.
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER				ENSE NUMBE			ED (Month, Day, Year)
2	Meodore Mr.	Knol 1	u.D.	0	.C.M.	E	DEC.	10,1994
	30. NAME AND ADDRESS OF PERSON WHO Theodore King M		DEATN (ITEM 27) (Type, Pri 111 Penn		Balti	imore, M	arylan	d 21201

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a forms after death. Page 8 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely flined in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

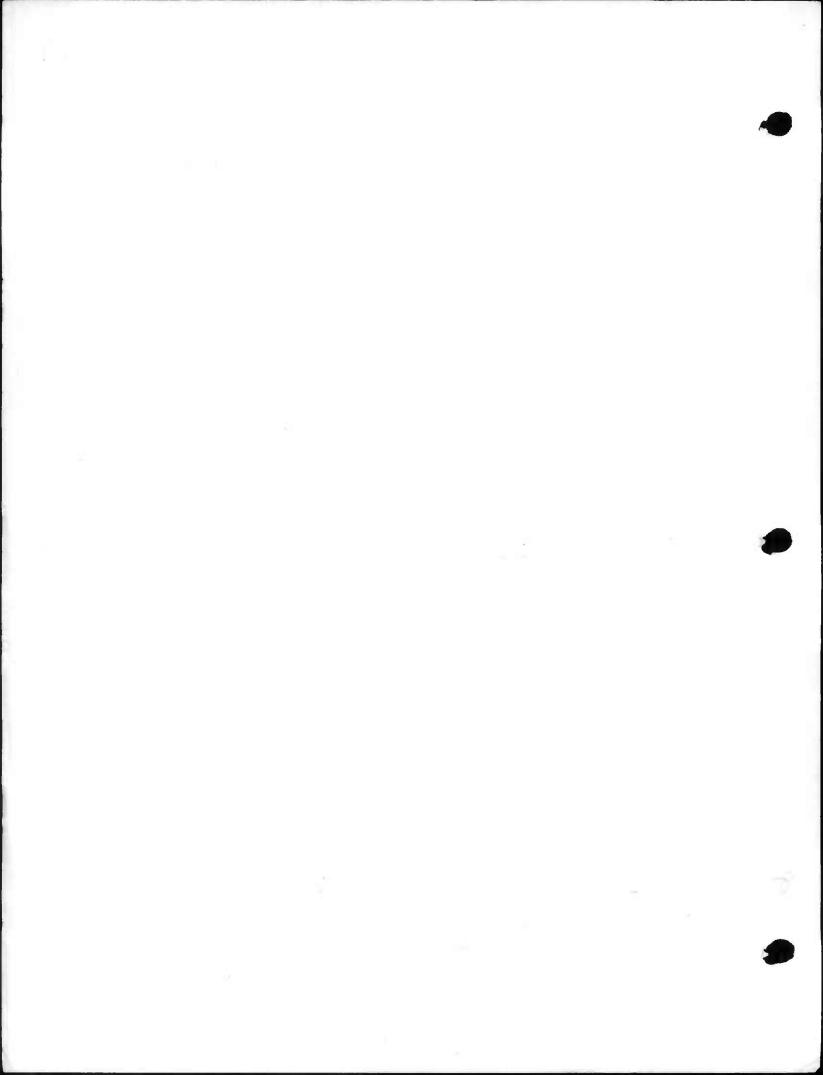
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIFIC	ATE OF DEATH	REG. N	0.			
	1. DECEDENT'S NAME (First, Middle, Last) Margaret E	How	P	2. DATE OF DEATH	13 94	3. TIME OF DEATH 20 A M		
			UNDER 1 YEAR IF UNDER 24 HI	Aldrest One Mant	8. BIF	RTNPLACE (State or Foreign untry)		
TOR	9a. FACILITY NAME (If not institution, give street and number) Deaton Specialty Hospital RESIDENCE OF GECEDENT	+Home. 1	Baltimore	Md.	9c. COUNTY OF	FDEATA		
DIRECTOR	Md. Baltimore	10c. CITY, TO	OWN OR LOCATION			10d. INSIDE CITY LIMITS? 1 YES 2 X NO		
FUNERAL	100. STREET AND NUMBER 1016 Cord St.		101. ZIP CODE 2122	1	10g. CITIZEN O	F WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YES, GIVE WAR OF THE PROPERTY OF THE PR	ES 2 NO	13. WAS DECENDENT OF NI If yes, specify Cuban, Mi 1 VES 2 NO S	xican, Puarto Rican, atc.)	В	ACE — American Indian, lack, While, atc. Decily: White		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	16a. DECEDENT'S USU (Give kind of work life. Do NOT use re Seamst	done during most of working tired.)	2 10 10 10 10 10 10 10 10 10 10 10 10 10	thing	′		
	17. FATNER'S NAME (First, Middle, Last) Salvadore DiDomenico	J Cambo	16. MOTNER	S NAME (First, Middle, Meio	en Surname)			
B	19a. INFORMANT'S NAME (Typo/Print)	196 MAILING AD	DRESS (Street and Number or F					
임	Sharon Hayden		Denbury Dr		ore, Md			
	20a. METNOD QE DISPOSITION 1 □ Buriel 2 ☑ Cremellon 3 □ Removal from State	20b. PLACE OF DISPOSITIO	ON (Name of cemetery, cremator)	/ or 20c.	LOCATION — CHy of	r Town, Slate		
	4 Donellon 5 Other (Specify)	Metro Cr	22. NAME AND ADDRESS O		altimor	e, Ma.		
	*anthony Cold Con	nelly	Connelly	Funeral lers Pt.	Home of Rd. 21	Dundalk 222		
	23. PART I. Enter the disease, or complications that caused the death. Dp not enter the mode of dying, such as cardiac or respiratory arreat, ehock, or heet allure. List only one cause on each line. IMMEDIATE CAUSE (Finel							
	disease or condition resulting in deeth) • SEPS	AS A CONSEQUENCE OF):				5-4 day 3		
ATION	Sequentielly list conditions, If any, leeding to immediate cause. Enter UNDERLYING							
CERTIFICATION	CAUSE (Disease or Injury that initiated events resulting in deeth) LAST oue TD (OR AS A CONSEQUENCE OF):							
	PART II. Other significant conditions contributing to deer MULTI BE STEDICES	th but not resulting in t	the underlying cause give	OTTA C PERI	ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
PHYSICIAN: MEDICAL	POSITIVE PPD		2103 11100	1 Q YES	2 XNO	OF DEATH?		
IAN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT	H (Check only one)				
Sic	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inputient 2 ER/	Outpatient 3 DOA 4	THER: Nursing Nome 5 - Reside	nce 6 🗆 Other (Specify)				
BY PHY	27. MANNER OF DEATH 1 Netural 5 Pending Investigation				W INJURY OCCURE)		
	2 Noticett	URY — Al home, farm, atre Specify)	et, factory, office	261. LOCATION (Streetly or Town, St	et and Number or Ru ste)	iral Route Number,		
COMPLETED	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my leading to the best of the best of the best of the best of the best of examiner.					se(a) and manner as stated.		
BE	296. SIGNATURE AND TITLE OF CERTIFIER	~~	29c. LICENS	NUMBER		NED (Month, Day, Year) EMBER 13 1894		
10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF BLANC. WALLACE W		- CHANUS	ST. BA.		M 21230		
	31. DATE FILED (Month, Day, Year) DECT 4 1994 Julia Dawdson Re	/	/	-				



FOR STATE REGISTRAR

31. DATE FILED (MO

1 -

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

94 37185

94

9c. COUNTY OF DEATH

UNITED

3. TIME OF DEATH

P.M

6:42

10d. IHSIDE CITY

STATES

14. RACE — American Indien, Black, White, atc.

BLACK

MD #02

AVENUE

24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO

1 YES 2 HO

DEC 9,1994

COMPLETION OF CAUSE

Approximate

intarvai Between

Onset and Dasth

1 VES 2 HO

8. BIRTHPLACE (State or Foreign

MARYLAND

n/a

10g. CITIZEH OF WHAT COUNTRY?

REG. NO.

1. DECEDENT'S HAME (First, Middle, Last) 2. DATE OF DEATH JACKSON DEC 08 DAVID JR. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH NOV . 15, 217-25-7218 5 DAYS 1 XM 2 F 1989 Pages 1, 2, 3 should 9a. FACILITY HAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR JOHNS HOPKINS HOSPITAL BALTIMORE CITY 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND n/a BALTIMORE permit. 10e. STREET AND HUMBER FUNERAL 10f. ZIP COOE 21202 use as the burial-transit 107 SOUTH STREET apt.40 ALBEMARLE after death. Page 6 may be retained by the hospital or attending physician 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 YOU NO IF YES, GIVE WAR OR DATES 13. WAS OECEHDENT OF HISPANIC ORIGIN? (Specify Yee or Ho—If yes, specify Cuban, Mexicen, Puerto Rican, atc.)

1 YES XIA HO Specify: BALTIMORE, MARYLAND 21215-0020 1) Hever Married 2 Married BY 3 Widowed 4 Divorced 5 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIHD OF BUSINESS/INDUSTRY (Specify only high Щ College (1-4 or 5+) the funeral director, page 5 should be detached for Elementary/Secondary (0-12) COMPL none CHILD n/a at once. 17. FATHER'S HAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) DAVID **JACK SON** MARLENE BAKER notified 19a. IHFORMAHT'S HAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DAVID A. JACKSON SOUTH ALBEMARLE STREET BALTIMORE. Pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF OISPOSITION (Name of 20c. LOCATIOH - City or Town, State DATE must Cremetion 3 - Removal from State MEMOR I AL GARDENS 12-15 DUNDALK, MARYLAND 4 Donation 5 Other (Specify) examiner 21. SIGHATURE OF FUNERAL SERVICE LICEHSEE 22. HAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, signed by the attending physician and completely filled in by . Health and Mental Hygiene prior to burial, cremation, or remo shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final the disease or condition resulting in death) KETOACIDOSIS other traumatic event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? any YES 2 NO shows ; this certificate has been with the State Dept. of I DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMIHER? HOSPITAL: OTHER:
4 ☐ Hursing Homa 5 ☐ Residence 6 ☐ Other (Specify) YES 2 HO 1 V Inpatient 2 ER/Outpatient 3 DOA 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. IHJURY AT WORK? 28d. DESCRIBE HOW IHJURY OCCURED marked, 1 Hatural JNKNOWN M DIRECTOR: After the hours after death v 2-6-94 1 YES 2 XXHO В 2 Accident Investigation 26a. PLACE OF IHJURY — At home, ferm, atreet, fectory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 99 3 Suicide COMPLETED 8XXX Could not be 4 Homicide 28 LINKNOWN item OR 29a. CERTIFIER 1 CERTIFYING PHYSICIAH: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. FUNERAL within 72 h HOSPITAL = TO THE HOSPITA
TO THE FUNERA
De filed within 7. 2 😾 MEDICAL EXAMIHER: On the basis of exemination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) end manner as stated, 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE HUMBER 29d. DATE SIGHEO (Month, Day, Year) BE 30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

THEORORE 11 O.C.M.E. 2 DIORE 111 Penn Street, Baltimore, Maryland 21201

32. AEC

YEAR

3. TIME OF DEATH

REG. NO

2. DATE OF DEATH

FOR

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STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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70112V 18 Doca 4. SOCIAL SECURITY NUM 8. AGE (In yrs. lest birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 - F 66-54-0949 HOURS Michigan (bar) use as the burial-transit permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Owings Mills 9 Wellhaven Circle Apt. 1025 DIRECTOR Baltimore RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE MD OWINGS 1 TYES 2 K NO MILL FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21117 U.S.A. 9 Wellhaven Circle Apt. 1025 after death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If was specify Cuben, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 W Married If yes, specify Cuben, Mexican, Puerto Ri
1 ☐ YES 2 📉 NO Specify: IF YES, GIVE WAR OR DATES В 3 Widowed 4 Divorced Specific White COMPLETED 15. DECEDENT'S EDUCATION pecify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 165 KIND OF BUSINESS/INDUSTRY (Sne Q Elementary/Secondary (0-12) College (1-4 or 5+) Retail Sales 12 mage 5 should be detached 2 Salesman 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Sumame) Barbara Ritsema E. James Johnson notified at BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9 Wellhaven Circle Apt. 1025, Owings Mills, Md.21117 2 Mary K. Johnson 2 20b. PLACE AND DATE OF OISPOSITION (Name of 20c. LOCATION — City or Town, State must DATE director Metro Crematory Dec. 13, 1994 Baltimore, Md. examiner 21. SIGNATURE OF FUNERAL SERVICE LICE 22. NAME AND ADDRESS OF FACILITY filled in by the funeral 21117 Eckhardt Funeral Chapel 11605 Reisterstown Rd., Owings Mills, Md. medical 23. PART I. Enfer the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Deeth IMMEDIATE CAUSE (Final ä disease or condition_ completely resulting in death) 2045 ij traumatic event, burlal. esecuted CERTIFICATION has been signed by the attending physician and on Dept. or Health and Mental Hygiene prior to buri Sequentially list conditions, EQUENCE OF if any, leading to immediate cause. Enter UNDERLYING 2 CAUSE (Disease or Injury that initiated events resulting in death) LAST certificate other DUE TO (OR AS A CONSEQUENCE OF) ä the death injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24ti. WERE AUTOPSY FINDINGS shows any Ħ AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 10 T TYES 2 THO PHYSICIAN: À 2 25. WAS CASE REFERRED TO MEDICAL EXAMPLER? Z Hell 26, PLACE OF DEATH, Check only one OR ATTENDING PHYSICIAN. The DIRECTOR After this certificate flours after death with the State OTHER: 1 | Impatient 2 | ER/Outpatient 3 | DOA 8 EN OF DEATH 28s. DATE OF INJURY (Month, Day, War) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 5 Pending Investiga BY 1 YES 2 NO Accident 25e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 | Suicide 29f. LOCATION (Street and Number or Rural Route Number, City or Team, State) 30 COMPLETED 6 [] Could not be 4 Homicide 82 Hell 1 CERTIFFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mar TO THE HOSPITAL.
TO THE FLINESAL.
TO Shed within 72 th
IMPORTANT: If I PLINESAL WITHIN 72.1 HOSPITAL 2 DEDICAL EXAMINER: On the basis of exami BE DEXAMIN 1994 00108 2 1994 DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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S, P.O. B	death certificat
DS, P.O. B	the death certificate
RDS, P.O. B	at the death certificat
ORDS, P.O. B	s that the death certificate
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RECORDS, P.O. B	equires that the death certificate
RECORDS, P.O. B	w requires that the death certificate
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I OF VITAL RECORDS, P.O. B	PHYSICIAN: The law requires that the death certificate
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ION OF VITAL RECORDS, P.O. B	VDING PHYSICIAN: The law requires that the death certificate
SION OF VITAL RECORDS, P.O. B	TENDING PHYSICIAN: The law requires that the death certificate
VISION OF VITAL RECORDS, P.O. B	ATTENDING PHYSICIAN: The law requires that the death certificate
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	L OR ATTENDING PHYSICIAN: The law requires that the death certificate

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT	OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE	OF DEATH	REG NO

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)		03/11/11	ALE OF	DEATH	2. DATE OF OEATH		3. TIME OF DEATH	
1	GEORGE	THOMAS	KING SR.			DEC. 12	2 94	4:00 AM	
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (n yrs. last birthday)	F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	6. BIRT	THPLACE (State or Foreign	
	214 54 6667	1 Å м 2 □ F 45	YRS.	ONTHS DAYS	HOURS MIN.	07"01" 49	Mar	yland	
œ	9a. FACILITY NAME (If not institution, give		arbut	OR LOCATION OF DEA	АТН	9c. COUNTY OF	HTA30		
07.	1550 CATON C	ENTER DRIVE		ALDUL	.us		BALTI	MORE	
DIRECTOR	100. STATE 106. COUNT	Y		rown or Local	ore City			10d. INSIDE CITY	
	10e. STREET AND NUMBER							14 YES 2 NO	
FUNERAL	2834 Hudson St	reet			1224		USA	WHAT COUNTRY?	
UNE	11. MARITAL STATUS	12. WAS DECEDENT EVER IN		13. WAS DEC	ENDENT OF HISPANI	C ORIGIN? (Specify Yea	or No.— 14. RAG	CE American Indian,	
BY F	1 Never Merried 2 X Married 3 Widowed 4 Divorced	FORCES? 1 TYPES		If yes, sp	ecify Cuban, Maxican. 2 2 NO Specify:		Bla	ck, White, etc.	
	15. OECEDENT'S EDU	Vietnam				<u> </u>	Whii	té	
ETE	(Specify only highest grad	completed) College (1-4 or 5+)	(Give kind of wor life. Do NOT use r	k done during mo	on st of working		SINESS/INDUSTRY		
APL.	c 12	Conege (1-4 or 5+)	Dispatch	her		Courier	Service	9	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					E (First, Middle, Maiden	Surname)		
BE	Walter E. Kir	ıg				Marker			
2	19a. INFORMANT'S NAME (Type/Print) Patricia L. Kin	ıa	2834 1	ooress (Street a Hudson	nd Number or Aural Ac Street Ba	alto., Md.	n, State, Zip Code) 21224		
		20b.	PLACE AND DATE OF	DISPOSITION (Ne	me of	DATE 20c. LO	CATION — City or 1	Town. State	
	20s. METHOD OF OISPOSITION **D Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MOST HOLY Redeemer Cem 12-16-94 Balto., Md.								
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		22. NAME AP	ID ADDRESS OF FACI	ler & Son			
	> Clarks	D. Jule	~			venue Bal			
	23. PART I. Enter the diseases, or ehock, or heert fellure.	compilcations that caused	the death. Do not	enter the mo	de of dying, such	as cerdiec or reepi	iratory arrest,	Approximate	
	Miles van Delween								
	disease or condition resulting in death) - every traverse of the dareleft Ann onset and Death								
_	DUE TO (OR AS A CONSEQUENCE OF):								
흔	Sequentielly list conditions, If any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF):								
S	ceuse. Enter UNDERLYING CAUSE (Disease or Injury								
CERTIFICATION	that Initiated evente DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST								
	d								
AL	PART ii. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY FINGINGS AMAILABLE PRIOR TO								
E	YES 2 □ NO COMPLETION OF CAUSE OF DEATH?								
N.	DID TOBACCO USE CONT	DIRLITE TO CALISE OF	DEATH VEC		LINICEDTAIN	_ ′ `		YES 2 NO	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH		UNCERTAIN	Ш			
SIC	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outpe		THER:	e 5 🗆 Realdence 6	▼ Other (Specify) 7	T WORK		
PH	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME C	F 28c. INJ	URY AT RK?	28d DESCRIBE HOW I	110000	1	
B⊀	1 Natural 5 Pending 2 Accident Investigation	19191	IUNK		rES 2 NO	Supred	Total	T/	
G	3 Suicide 6 Could not be determined	28a. PLACE OF INJURY building, atc. (Speci	At home, farm, stre	et, factory, office	'	28f. LOCATION (Street a City or Town, State)	and Number or Rural	Poute Number,	
9	29s. QSECTIFIER		1) - 47 1	رهي	/	550CA	1010 91	UNR.	
COMPLETED		ER: Of the best of my knowle						(a) and manner as stated	
	26. SIGNATURE AND TITLE OF CERTIFIE		. / 4/\		29c. LICENSE NUME			D (Month, Day, Year)	
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8	38. HAME AND ADDRESS OF PERSON WE	. A. A							
	V. THEN LO			Stree	t, Balt	imore, M	laryland	d 21201	
	DEC1 4 1994	32. AEGISTRAR'S SIGNA	TURE						
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BALTIMORE, MARYLAND 21215-0020
fter death. Page 6 may be retained by the hospital or attending physician.
the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Zer hours after death. Page 6 may be retained by the hospital	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to		
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	10	2	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	di

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
	MONTH				2. DATE OF DEATH MONTH DA	YEAR	B. TIME OF DEATH	
			yrs. last birthday)	F UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	94	ACE (State or Foreign	
	215-34-8633 t M 20 F 62 YRS. MONTHS DAYS HOURS MIN. 4/11/32 Virg						inia	
DIRECTOR	9a. FACILITY NAME (if not institution, give street and number) 8500 Glen Michael Lane (Res.) 9b. CITY, TOWN OR LOCATION OF DEATH Baltimore							
	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY,	OWN OR LOCATION		11	Od. INSIDE CITY	
	Maryland Balt	imore	Ra	ndallstown			LIMITS? YES 2 NO	
BY FUNERAL	8500 Glen Micha	el Lane 1	pt. 102	101. ZIP CODE 21133		10g. CITIZEN OF WH		
l S		2. WAS DECEDENT EVER IN FORCES? 1 YES		13. WAS DECENDENT OF NISP	ANIC ORIGIN? (Specify Yea		- American Indian,	
84	t There Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT		It yea, specify Cuban, Maxi 1 YES 2 NO Specific		Specify:	White, etc.	
	t5. DECEDENT'S EDUCAT (Specify only highest grade co.	TION	16a. DECEDENT'S US	UAL OCCUPATION	16b. KIND OF BUS	SINESS/INDUSTRY	Black	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use r		Fashi	on L.T.D		
g Z	12th		Ret					
	17. FATNER'S NAME (First, Middle, Last) Linwood Lawson				AME (First, Middle, Melden P Jackson	Surname)		
	19a. INFORMANT'S NAME (Type/Print)		19b, MAILING AL	DRESS (Street and Number or Run		State Zin Codes	21133	
TO B	Marie Shell			Glen Michae		andal1st		
must be	20a. METNOD OF DISPOSITION **Disposition 3 Remove	al from State	King Memo	DISPOSITION Park	20	CATION City or Town		
	4 Donation Other (Specify)		Bro Kee	COME AND ADDRESS OF		ltimore,	Md.	
וופ וופחורם באשוווופן	MOLI	7) (()	1	LEROY O. D	YETT & SO	N FUNERA	L HOME	
ŭ d	4600 LIBERTY HEIGHTS AVENUE 21207 23. And Errier the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate							
	sheck, or heart fallure. Lie	nplications that caused it only one cause on ta	the death. Do not ch iine.	enter the mode of dying, at	ich as cardiac or reapi	ratory arreat,	Approximate interval Between	
	IMMEDIATE CAUSE (Final disease or condition							
Agur,	DUE TO (OR AS A CONSEQUENCE OF);							
NO	Sequentially flat conditions, b. Sleep Abrea							
ATIC	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING							
FIC	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A C	CONSEQUENCE OF				-	
CERTIFICATION	resulting in death) LAST						Ĺ	
	PART ii. Other significant conditions of	contribution to death but	t ant consistent in	ha and dan an analysis of	B 4 1 1			
	PART II. Other eignificant conditions contributing to death but not resulting in the uniterlying cause given in Part i. 24a. WAS AN AUTOPSY FINDINGS ANALIABLE PRIOR TO COMMITTED IN COUNTY FINDINGS ANALIABLE PRIOR TO COMMITTED IN COUNTY FINDINGS ANALIABLE PRIOR TO COMMITTED IN COUNTY FINDINGS ANALIABLE PRIOR TO COMMITTED IN COUNTY FINDINGS ANALIABLE PRIOR TO COMMITTED IN COUNTY FINDINGS ANALIABLE PRIOR TO COUNTY FINDINGS ANALIABLE PR							
MEDIC	COMPLETION OF CAUSE OF DEATH?							
2 2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	21	B. PLACE OF DEATH					
YSIC	1 TES 2 NO 1	OSPITAL: Inputient 2 ER/Output		THER: Nursing Home 5 Residence	t 6 ☐ Other (Specify)			
H	27. MANNER OF DEATN 1. Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b, TIME C	WORK?	28d. DESCRIBE HOW IN	JURY OCCURED		
B	2 Accident Investigation	260 BI ACE OF IN HIRV	At home down star	M 1 YES 2 NO				
COMPLETED	3 Suicide 8 Could not be datarmined	26a. PLACE OF INJURY building, etc. (Specif)	- At nome, term, erre	et, tactory, offica	28t. LOCATION (Street a City or Town, State)	nd Number or Rural Rou	te Number,	
PLE	29a. CERTIFIER 1 CERTIFYING PHYSICIA	IN: To the best of my knowle	dga, death occurred a	t the time, data and place, and de	a to the cause(a) and man	ner as stated.		
WO				n my opinion, death occured at th			nd manner as stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIER			29¢ LICENSE N	UMBER	29d. DATE SIGNED (M	lonth, Day, Year)	
TO B	The	wo of	<u>C</u>	025	112	12/14	194	
T F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
	5310 Old Co-	wor Fo	Ka	ndalls	own M	11) XII	33	

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BALTIMORE, MARYLAND 21215-0020

Pages 1, 2, 3 should

permit.

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

burial-transit Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for use as the the attending physician and completely filled in by Mental Hygiene prior to burial, cremation, or remo been signed by the DIRECTOR: After this certificate has be hours after death with the State Dept. OR ATTENDING PHYSICIAN: The TO THE HOSPITAL
TO THE FUNERAL I
be filed within 72 h
IMPORTANT: If it HOSPITAL

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH LOVING RONALD Ronald W. Loyins 10.30 12 08 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 8. BIRTHPLACE (State or Foreign Country) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS DAYS 1 M 2 [] F YRS. 306-80-7596 Columbus, 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN 7514 Collins St. DIRECTOR Pittaville Wicomico RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Wicomico Pittaville 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7514 Collins St. 21850 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES YNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married t ☐ YES 2 NO Specify: Specify: White BY 3 Wildowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g. Elementary/Secondary (0-12) College (1-4 or 5+) Computer Programer Computer Co. 12 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Ronald W. Lovins Velma Beaver notified at 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ronald 2510 525 Columbus In. 99 20a. METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 20a, METHOD OF DISPOSITION

1 Burlel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) rematory

22. NAME AND ADDRESS OF FACILITY Columbus. medical examiner 21. SIGNATUJE OF SUIJERAL SERVICE LIGENSEE Skanda Funeral Home 2829 Hudson Balto. . Md. St. complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, 23. PART I. Enter the diseases, of ahock, or heart fellura List only one cause on each line. Interval Batwe **IMMEDIATE CAUSE (Finel Onset and Death** the diseese or condition_ CMV ENCEPHALITIS 2 MOS resulting in death) traumatic event. DUE TO (OR AS A CONSEQUENCE OF): CELLULAR IMMUNODEGCIEVCY 3 YRS CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate ceuse. Enter UNDERLYING HUMAN IMMUNODEFICIENCY MRUS other CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evente reculting in deeth) LAST 0 PART II. Other eignificent conditione contributing to deeth but not reculting in the underlying cause given in Pert I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? CMV RADICULOPATHY 1 YES 2 NO I TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO YOU UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER 1 YES 2 NO ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Nome 5 Realdence 6 ☐ Other (Specify) 0 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural
2 Accident 1 YES ВУ Investigation 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED e Could not be 28 4 Homicide detarmined item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date and place, and due to the cause(a) and menner ea stated. (Check only one) mination and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(a) and manner as atated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) 8 tust Charles McMotion MD 194 A27666 5 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

JOHNS HOPKINS HOSPITAL, 21287-7609



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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMO	_
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31. DATE FILED (Month, Day, Year)

DEC 1 4 1994

32, REGISTRAR'S SIGNATURE Julia Davidson Randall

permit. Pages 1, 2, 3 should the funeral director, page 5 should be detached for use as the burial-transit 6 may be retained by the hospital or attending physician. notified at once. pe must examiner medical completely filled in by 0 the cremation, other traumatic event. bunial, and prior to physician the attending phy I Mental Hygiene p 6 shows any injury, signed by the peed Dept. item 23 certificate h 6 marked, this (DIRECTOR: after 28 TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 ho

ITEMS: 12. & 19b. PER F.H. FILM G-718 12/14/94 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH 3. TIME OF DEATH LAWSON MAGGIE As H 12-12-94 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 1 M 2 - F DAYS HOURS YAS 216-24-6092 4-15-1905 9s. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 2429 F. PI DIRECTOR 10s. STATE toc. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? md. BAITO YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 2429 E. Pres 2/2/3 WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 LIVES 2 X NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or It yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. Never Married 2 Msrried 1 YES 2 NO Specify: BY Widowed 4 Divorced ED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY COMPLET (0-12)College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Nor 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS 2 20s. METHOD OF DISPOSITION
1 Surial 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 1 Burisi 2 Cremetion 3 L Donetion 5 Cother (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY alleia Hone MA 23. PART I. Entar the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Daath disease or condition Stroke weeks resulting in death) DUE TO (OR AS A CONSEQUENCE OF): pertension years CERTIFICATION Sequantially list conditions, DUE TOWER AS A CONSEQUENCE OF If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseasa or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO MEDICAL Coronary artery disease COMPLETION OF CAUSE 1 | YES 2 | 110 t YES 2 TO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural Pending 1 YES BY Investigation 2 Accident 26e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be 4 Homicide 29s. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as atteted. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE BBross D35199 12/13/94 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

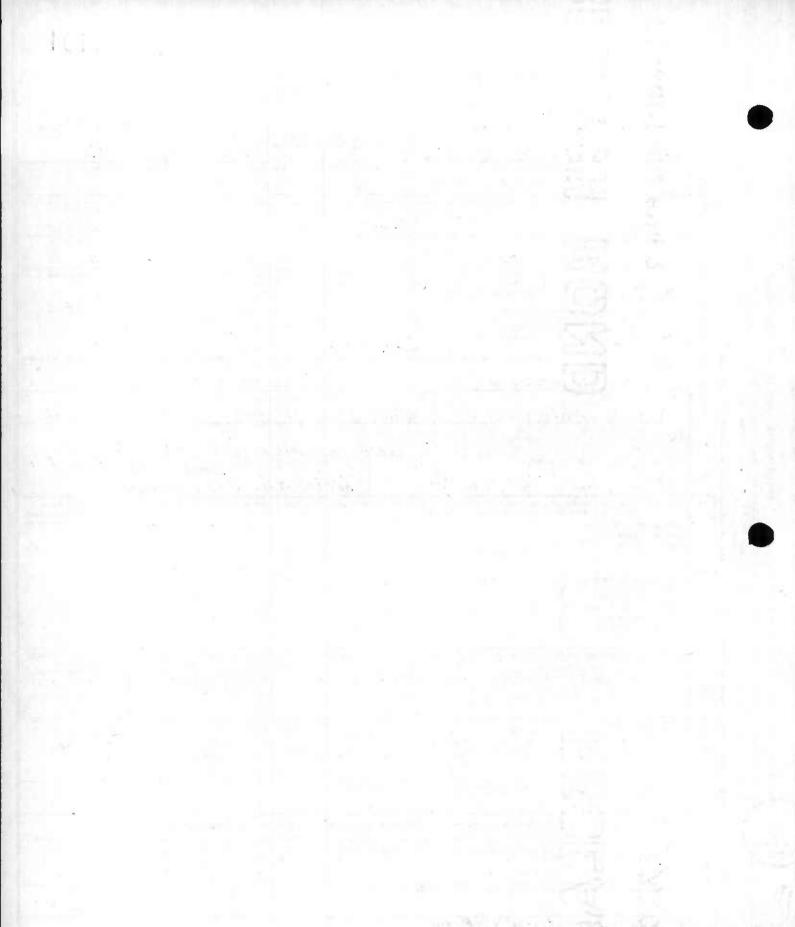
Fire B. Buss, Md 1830 E Monument 5+, Rm 8060

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Bultimore MA

BALTIMORE, MARYLAND 21215-0020	ours after the law requires that the death certificate be executed with	t certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in the State Dept. of health and Mental Hygene prior to burial, cremation, or removal.	medical examiner must be notified at once.
TEIVISION OF VITAL RECORDS, P.O. BOX 68760.	TO THE LOSPITAL OR LITERONG PHYSICIAN: The law requires that the death certificate be executed with	TO THE FUNCENE ENFECTION: After this certificate has been signed by the attending physician and completely filled in by the the fleet within 72 hours after death with the State Dept. of health and Mental Hygene prior to burist, cremation, or removal.	IMPORTANT: If Item 28 it marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE REGISTRAR	STATE OF MARY		T OF HEALTH AND	MENTAL HYGIE REG. NO						
1. DECEDENT'S NAME (First, MI	2 T. Lews	IAK		2. DATE OF OEATH	2 194	3. TIME OF OEATH				
4. SOCIAL SECURITY NUMBER 2 6 - 10- 90. FACILITY NAME (If not institute)	679 1XM2 0 F	82 YRS. MONTHS		7. DATE OF BIRTH (Month, Day, Year)	1912 00	ATHPLACE (State or Foreign unitry)				
CHUR OF DECE	CH HOME + HE	5P. B	ALT, MORE		9c. COUNTY OF	FDEATH				
MD.	b. COUNTY	BAUT	OR LOCATION MORE			10d. INSIDE CITY LIMITS? 1 YES 2 \(\square\) NO				
	UDSON ST.		2/22		U.	5 A				
11. MARITAL STATUS 1 Never Married 2 Ma 3 Widowed 4 Divorce	JE VES GIVE WAR OR I	2 NO	I. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic 1 YES 2 NO Speci	an, Puerlo Rican, atc.)	BI	ACE — American Indian, lack, White, etc.				
	ENT'S EDUCATION ghest grade completed) College (1-4 or 5+)	16a. DECEDENT'S USUAL (Give kind of work done life. Do NOT use retired.	during most of working)	-	USINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle TO SEDH	LEJSIAK	711802	18. MOTHER'S N	AME (First, Middle, Maide ANDA	O ZANSH	Ki'				
190. INFORMANT'S NAME (Typo WANDA J	190. INFORMANT'S NAME (TYPEPTIM). 190. MAILING ADDRESS (Street and Number of Flural Route Number, City or Town, State, Zip Code) 190. MAILING ADDRESS (Street and Number of Flural Route Number, City or Town, State, Zip Code) 190. MAILING ADDRESS (Street and Number of Flural Route Number, City or Town, State, Zip Code) 190. MAILING ADDRESS (Street and Number of Flural Route Number, City or Town, State, Zip Code)									
4 Donation 5 Other (Sc	20e. METHOD OF DISPOSITION 1 Seurial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20e. DATE 20e. LOCATION - City or Town, State 20e. LOCATION - City or Town, State 20e. LOCATION - City or Town, State 20e. LOCATION - City or Town, State 20e. LOCATION - City or Town, State 20e. LOCATION - City or Town, State 20e. LOCATION - City or Town, State 20e. LOCATION - City or Town, State 20e. LOCATION - City or Town, State 21e. SIGNATURE OF FUNERAL SERVICE, LICENSEE									
. Thors	2 J. Skarlo	h.	KARDA FEH	2829	HUDSON	57.				
shock, or head iMMEDIATE CAUSE (Fine) disease or condition resulting in death)	esas, or complications that cause of failure. List only one cause on s. Prisu Due To (OR AS	A CONSEQUENCE OF):	er that mode of dying, su	on as cardiec or rea	piratory arreat,	Approximata Interval Batwee Onset end Deat				
If any, leading to immedia cause. Enter UNDERLYING										
	PART II. Other significent conditions contributing to death but not resulting in the underlying cause MULT (PLE MYECOMA					24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO				
25. WAS CASE REFERRED TO MEXAMINER?			28. PLACE OF DEATH (C	heck only one)						
1 TYES 2 NO	HOSPITAL:	potient 3 DOA 4 No	ER: ursing Home 5 - Residence	6 Other (Specify)						
27. MANNER OF DEATH 1 Netural 5 Per 2 Accident	28e. DATE OF INJURY (Month, Day, Year) astigation	28b. TIME OF INJURY M	26c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW	/ INJURY OCCURED					
Accident Investigation Suicide						al Route Number,				
						e(s) end manner es stated.				
A.P. N	azemi mo				29d. DATE SIGN	(2/94				
(Check only 1/2 CERTIFFING PRYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) and manner se atsted. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner se atsted.										

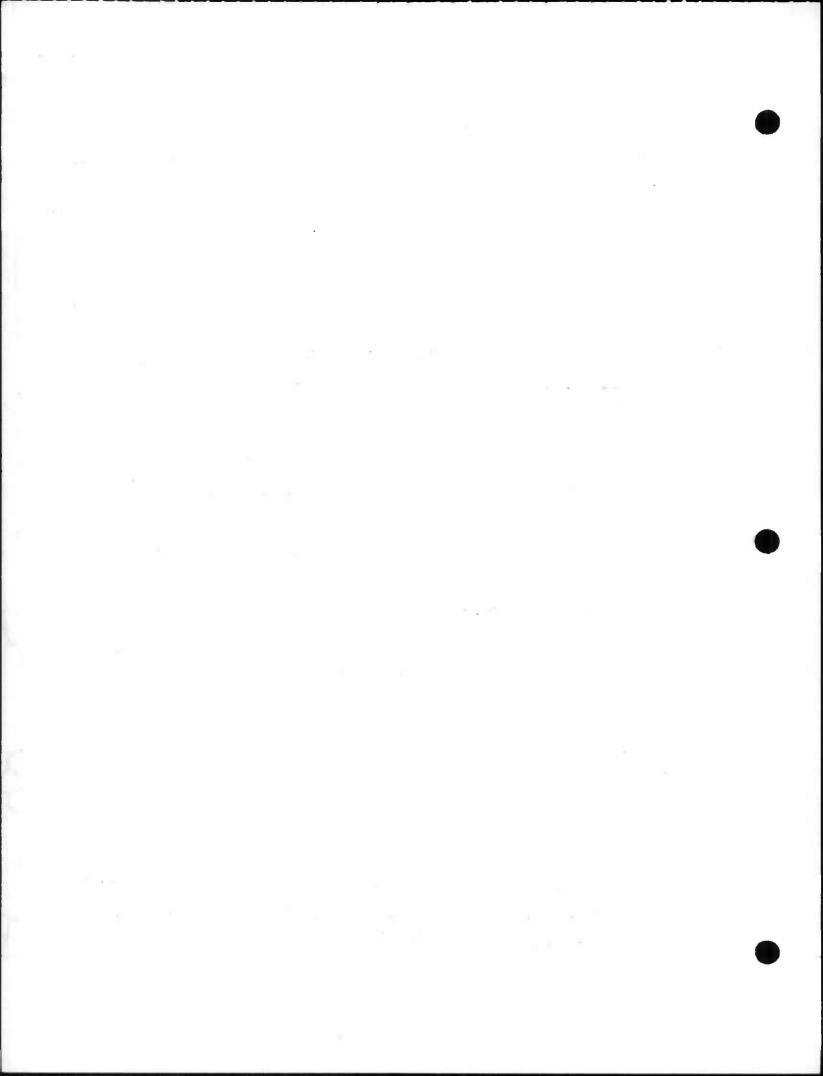


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ar hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM	MENT OF H	EALTH AND	MENTAL HYGIEN			
	1. DECEDENT'S HAME (First, Middle, Lest)					2. DATE OF DEATH		3. TIME OF DEATH	
	CHARLES I. M	1ATTHEWS				1.0		4 1000 P M	
		5. SEX 6. AGE (I		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	a.	BIRTHPLACE (State or Foreign	
	217-34-4190 9e. FACILITY NAME (If not institution, give stre-		54 YRS.	ONTHS DAYS	HOURS MIN.	5/18/194		alto., MD	
Œ	311 Lyndhurst		, ,		timore	EATH	9c. COUNTY	OF DEATH	
DIRECTOR	RESIDENCE OF DECEDENT			Dar	CIMOLE				
RE	10e. STATE 10b. COUNTY	-		OWN OR LOCAT				10d. INSIDE CITY LIMITS?	
	Maryland		Ba	ltimo	re			t X YES 2 □ NO	
FUNERAL	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CITIZE	OF WHAT COUNTRY?	
NE NE	311 Lyndhurst A				2122			USA	
F	11. MARITAL STATUS 1 ☐ Never Married 2 📈 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO			HC ORIGIH? (Specify Ye in, Puerto Ricen, etc.)	e or No- 14	. RACE — American Indian, Black, White, etc.	
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES	1 TYES	2 NO Specif	y:		Specify: Black	
0	15. DECEDENT'S EDUCA	TION	16a. DECEDENT'S US			16b. KIND OF BU	SINESS/INDUS		
Ē	(Specify only highest grade co	College (1-4 or 5+)	(Give kind of work life. Do NOT use n	done during mo etired.)	st of working	Midaha	110 5	Varehouse	
AP	12th		Fork Li	ift Dr	iver	Michae	er's v	varenouse	
COMPLETED	17. FATHER'S HAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maider	Surname)		
BE	James Norm	ian			Beatr	ice Eliz	a Mat	thes	
2	19e. IHFORMANT'S NAME (Type/Print)					Route Number, City or Tov			
	Dorothy Matthew		311 1	yndhu	rst Ave	nue Bal	timor	e, MD 21229	
	20e. METHOD OF DISPOSITIOH 1 Burlet 2 Cremetion 3 Remove	al from State 20b.	PLACE AHD DATE OF Detery, crematory or other	DISPOSITION (Ne	me of 12/1	5 DATE 20c. LC		or Town, State	
	4 Donation 5 Other (Specify)	Ma	etery, cremetory or other aryland	Natio:	nal Cem	I.a	urel,	Maryland	
	21. SIGNATURE OF POWERAL SERVICE LICE	1 1	1-1-	IJERO	Y O. DY	ETT & SO	N FUN	ERAL HOME	
	MULL	1 New	4	4600	LIBERT	Y HEIGHT	SAVE	NUE 21207	
	23. PART Littler the diseases, or cou	mplicetions that caused	the deeth. Do not	enter the mo	de of dying, suc	h ss cerdiac or resp	iratory arrest	Approximate interval Between	
	IMMEDIATE CAUSE (Finel		4					Onset and Death	
	disease or condition a. Myo cardial Inforction 2h								
Z	Sequentieily ilst conditions, b.	BILMS	mosel	ero	21,5			10 years	
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	. 1	CONSEQUENCE OF):	0 1					
임	CAUSE (Disease or Injury C.		CONSEQUENCE OF:	5100	^_			10 years	
Ē	that initieted evente resulting in deeth) LAST							i `	
S	d.								
AL	PART II. Other significent conditions	contributing to deeth bu	it not resulting in t	he underlying	cause given in	Pert I. 24a, WAS AN PERFO		24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO	
Dig	Bitateral	Occipit	21 54	roke	5	1 YES :	Kno	COMPLETION DF CAUSE OF DEATH?	
							/	t 🗌 YES 2 🗍 NO	
ä	DID TOBACCO USE CONTRI			/	UNCERTAI	V []			
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	6. PLACE OF DEATH (
1 YES 2 HO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home						8 Other (Specify)			
	27. MANNER OF DEATH 1 Natural 5 Pending	(Month, Day, Year)	28b. TIME O	Y WO	BK?	28d. DESCRIBE HOW	NJURY OCCUR	ED	
B	2 Accident Investigation	20. BL 405 OF IN HIM			ES 2 NO				
8	3 Suicide 8 Could not be determined 4 Homicide 8 Could not be determined 4 City or Yown, State) 280. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)								
<u>L</u>	204 CEPTIEIER								
S Could not be determined building, etc. (Specify) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of my knowledge, death occurred at the time, date and place, and due to the cause(e) and menner es at ted.									
2 MEDICAL EXAMINER: On the basic of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) and menner se state							suse(e) end menner ee stated.		
B	29b. SIGNATURE AND TITLE OF CERTIFIER	N. C. I Y	2-11 -	_	29c. LICENSE NUN	ABER	29d. DATE SI	GNED (Month, Day, Year)	
2	30 MAME AND ADDRESS OF PERSON WHO	1/201001 K	esiden/		9079	6	12	112/94	
	TUAN MENKE	LJ 900	CATON	Au o	Saltin	none M	DZ	1229	
	31. DATE FILED (Month, Day, Year)	32. PEGISTRAR'S SIGNA							
- 1	DEC1 4 1994	WILLIAM AUTOMA	M. S. SELECTOR						



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OR	DIR	te
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by me may	TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be decaded by the filed within 72 hours after death with the State Dect. of Health and Mental Housene prior to burial, cemarition, or removal	IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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31. DATE FILED MONTO

ransit permit. Pages 1, 2, 3 should

	Items1,9b,17,19a&b,g-718.	12-14-94,pe	rf.h.,	dr				94	3	1193
	1 - STATE (STATE REGISTRAR	F MARYLAND		TMENT OF		D MEN	TAL HYGIEN			,
	1. DECEDENT'S NAME (First, Middle, Last)			IOAIL OI	DEATH	10.0				
- 3	MARDELL	111 0 - 2011						AY	YEAR	TIME OF DEATH
		MARTIN	Ma	rdeli Pea	rl Martin			9	4 1	/2 - P M
	4. SOCIAL SECURITY NUMBER 5. SEX	8. AGE (In yrs. la.	st birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR		ATE OF BIRTH			ACE (State or Foreign
	220 05 730/ 1 M 2)	G 72	YRS.	MONTHS DAYS	HOURS MR		onth, Day, Year)	1922	Mary	land
	9a. FACILITY NAME (If not institution, give street and number	r)		9h CITY TOWN	OR LOCATION O		pc. 27,		ITY OF OEA	
œ		,		l						
2	Mercy Hospital			Baltin	ore City			Bal	timor	e
S	10a. STATE 10b. COUNTY		I too CIT	Y. TOWN OR LOC	NTION				1.	0d. INSIDE CITY
DIRECTOR	36 1 1 37/4									LIMITS?
	Maryland N/A		Бал	ltimore					1	X YES 2 NO
¥	10e. STREET AND NUMBER			1	M. ZIP CODE			10g. CITE	ZEN OF WH	AT COUNTRY?
E	3775 Ravenwood Avenue				21213			U.S	. A.	
FUNERAL	11. MARITAL STATUS 12. WAS DEC	EDENT EVER IN U.S. AF	RMED	13. WAS DE	CENDENT OF HIS	SPANIC OF	HGIN? (Specify Yes	or No-	14, RACE -	- American Indien,
4		1 YES 2 X	NO	If yes, t	pecify Cuben, Me S 2 X NO Sc	xicen, Pue	rio Rican, etc.)		Black, V	White, etc.
BY	3 X Widowed 4 Olvorced	TE THE ON BAIES		10 16	a z M MO ak	эвспу:			Specify:	White
A	15. DECEDENT'S EDUCATION	16a, DI	CEDENT'S	USUAL OCCUPAT	ION		16b. KIND OF BU	SINESS/IND	HETDY	
看	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4)	life:	live kind of v	work done during n	ost of working	- 1				
7	Elementary/Secondary (0-12)		omema	kor			Own Ho	m o		
COMPLETED	IN / A IN / A 17. FATHER'S NAME (First, Middle, Last)		Omema	ikel						
S							rst, Middle, Meiden	Surneme)		
BE	Jess Horn Jesse Horn						Fryer			
2	19e. INFORMANT'S NAME (Type/Print)	19	b. MAILING	ADDRESS (Street	end Number or Ru	ural Route I	Yumber, City or Tow	n, Stete, Zip	Code)	
F	Jessie James Jessie Price (SO	1) 2	24 Di	wig Roa	d, New	7 Fre	edom, P	a. 1	7349	
1	20a, METHOD OF DISPOSITION	20b. PLACE	AND DATE	OF DISPOSITION (lame of				City or Town	. Stata
1	t X Buriel 2 ☐ Cremetion 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	cametery, cre	matory c- ~	"National Natioar	1 Cem	12				Maryland
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Darci	more		ND ADDRESS OF			I C IMO	10, 1.	laryrand
	· Mt 11-	1			unek Fu					
	"Multies O Capi	a					, Balti	more.	Md.	21213
	23. PART i. Entar the disassas, or complications	that caused the de	eath. Do n							Approximate
	shock, or hasrt failure. List only one	causa on each ilne	1.		, ,					interval Between
	iMMEDIATE CAUSE (Fine) disease or condition	,								Onset and Dasth
	resulting in death) a.	ENTRI OUCH	240	1131	REATT	LA				
			OUENCE OF	F):						
Z	Consumption in the constitutions	4SCVD								
Ĕ	if any, leading to immediate	E TO (OR AS A CONSE	OUENCE OF	F):						
2	CAUSE (Disease or injury									
ERTIFICATION	that initiated events	E TO (OR AS A CONSE	OUENCE OF	F):						
E	resulting in death) LAST									1
2										
A	PART ii. Other aignificant conditions contribution		-		ig cause given	in Part	. 24a. WAS AN PERFOR			ERE AUTOPSY FINDINGS MILABLE PRIOR TO
MEDICAL	Lower OI BO	red,	COPI	0			1 TYES 2	. 4	C	OMPLETION OF CAUSE
回										F DEATH?
2	DID TOBACCO USE CONTRIBUTE TO	CALISE OF DEA	TH VE	c KY NO I	7 UNICEDE	AINLE	,			YES 2 NO
A	25. WAS CASE REFERRED TO MEDICAL			TH (Check only one		AIN L	J			
0	EXAMINER? HOSPITAL		E OF DEAL	OTHER:)					
PHYSICIAN:		2 ER/Outpatient 3	DOA	4 - Nursing Ho	ne 5 🗌 Rasiden	nce 8 🗆 (Other (Specify)			
표	· A	E OF INJURY oth, Day, Year)	28b. TIMI INJ		JURY AT ORK?	28d.	DESCRIBE HOW I	NJURY OCC	URED	
Β¥	1 Natural 5 Pending 2 Accident Investigation			M 1 🗆	YES 2 ND					
	3 Suicide 26a. PLA	CE OF INJURY — At he ding, atc. (Specify)	me, farm, s	street, factory, off	ca		LOCATION (Street	and Number	or Rural Rou	te Number,
COMPLETED	4 Homicide determined	(-proof)					City or Town, State)			
"	29e. CERTIFIER				0.04 20 000					
MP	(Check only 108 CENTIFTING PHYSICIAN: 10 the be									
ō l	2 MEDICAL EXAMINER: On the besid	or examination end/or	inveatigatio	n, in my opinion,	death occured at	the time,	date end place, en	d due to the	Ceuse(s) e	nd manner as stated.
ш	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE	NUMBER		29d. DATE	SIGNED (M	lonth, Day, Year)
8	01.00	100 40	3.5		134	048	20	> /	12/8	194
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED	CAUSE OF DEATH (ITE	M 27) (Type,	Print) CSIN	BELA	IR.	BOAN		1	1
	FORNANDO J. FE	RRO, M.	0.		70 . 1	20	21206	4		
1				1-142	10 , 1		RICOL	-		

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be netified at once.

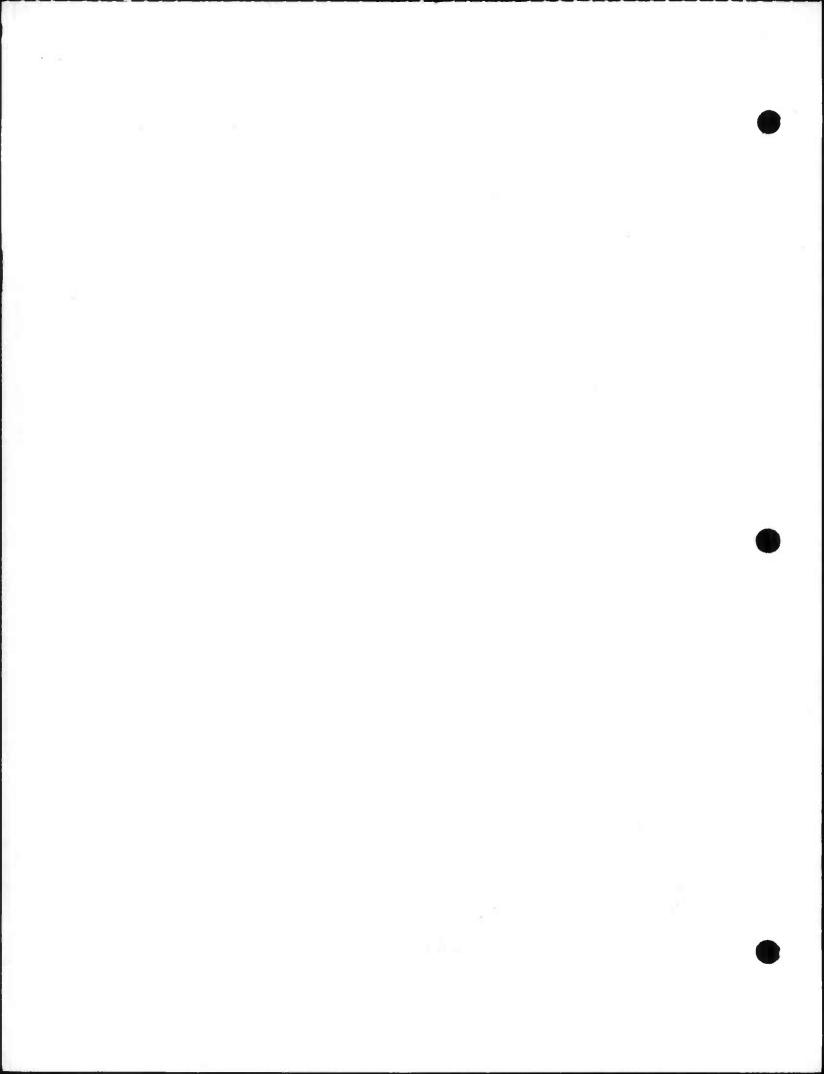
										2	**	0/194
	1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR ERTIF	ITMENT	OF H	EALTH DEAT	AND I	MENTAL HYGIEN			
	1. OECEDENT'S NAME (First, Middle, Last)			 -					2. DATE OF DEATH			3. TIME OF OEATH
	ETHEL			M	ERRY	MAN		DEC	TEMBER 4	199	94	6:12 A N
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las		IF UNDER		IF UNDER		7. DATE OF BIRTH		6. BIRTHE	PLACE (State or Foreign
	212-09-8261	1 🗌 M 2 💢 F	81	YRS.	MONTHS	DAYS	HOURE	MIN.	(Month, Day, Year) APR. 11, 19	13	Country MAR	y YLAND
	9a. FACILITY NAME (If not institution, give str	reet and number)			9b. CITY	, TOWN O	R LOCATIO	N OF OE		_	NTY OF DE	
H.	820 SOUTH CATO	N AVENI	IE			DΛ	LTIM	// DI		200		De
5	820 SOUTH CATO	N AVEN	7 🕒			DA	PITI	IOKI	<u> </u>			
DIRECTOR	10a. STATE 10b. COUNTY			10c, CIT	Y, TOWN C	R LOCAT	ION					10d. INSIDE CITY LIMITS?
	MARYLAND				BALT	IMOR	E					1 X YES 2 NO
¥	10e. STREET AND NUMBER					101.	ZIP CODE			10g. CITI	ZEN OF W	HAT COUNTRY?
FUNERAL	820 ^S CATON AVENUE						2	1229)		U	.S.A.
5	11. MARITAL STATUS		T EVER IN U.S. AR		13.	WAS DEC	ENCENT OF	HISPAN	IIC ORIGIN? (Specify Ye	or No-	14. RACE	- American Indian
ВУ	1 Never Married 2 X Married 3 Widowed 4 Olvorced	IF YES, GIVE Y	WAR OR DATES	10			2 X NO		n, Puarto Rican, etc.)		Specify	, While, atc.
												WHILE
H	15. DECEDENT'S EDUC (Specify only highest grade of		(G/	ve kind of a	USUAL O	CCUPATIO	N st of working	7	16b, KIND OF BU	SINESS/INC	USTRY	
Ä	Elementary/Secondary (0-12)	College (1-4 or 5	P)	Do NOT us								
COMPLETED	UNKNOWN		HO	MEMA	KER					EMAKI	NG	
	17. FATHER'S NAME (First, Middle, Last)								ME (First, Middle, Maiden	Surname)		
BE	CHARLES BIGGS							ARA		NOWN		
ဥ	190. INFORMANT'S NAME (Type/Print) JOSEPH MERRYMAN								Route Number, City or Tow			
.								BAL	TIMORE, MI		1229	
	20a. METHOD OF DISPOSITION Y☐ Burlal 2 ☐ Cremalion 3 ☐ Ramo	val from Stata	20b. PLACE A cemetery, crei	matory or o	ther placel					CATION —		rn, Stata
	4 Donation 5 Other (Specify)		MEADOW	RIDG				_	10-12-ELE	KRIDG	E	
	21. SIGNATURE OF PURPOSE SERVICE DIC	/ (OJI		- 1		O ADDRES			10		
	Velino	7	NA)	41	BBAK N7 W	TIKEN	NEKA NS A	L HOME, IN	TMOR	F MI	D 21229
	23. PART I. Enter the diseases, or complications that caded the death. Do not enter the mode of dying, such as cardiac or resolutiony errest.							Approximate				
	ehock, or heert fellure. List only pie ceuse on eech line.							Intervel Between Onset and Death				
	disease or condition	or condition										
	DUE 10 (0) AS A CONSEQUENCE OF):								-			
z	Cordio Vaguelan Il Feorl											
CERTIFICATION	Sequentially list conditions, If any, leeding to immediate	OUE TO	OUE TO (OR AS A CONSEQUENCE OF):									
8	ceuse. Enter UNDERLYING CAUSE (Disease or Injury	•										
ΕI	thet initiated events	OUE TO	(OR AS A CONSEC	DUENCE OF	F):							
H	resulting in death) LAST	•										
- ·	PART II. Other eignificent conditions	contributing to	death but not re	eculting	n the un	derivino	ceuse al	ven in	Part I. 24a. WAS AN	AUTOREY	245	WERE AUTOPSY FINDINGS
S						,	John St.		PERFO			AWAILABLE PRIOR TO COMPLETION OF CAUSE
									YES 2	□ NO		OF DEATH?
Σ	DID TODACCO LIST CONTO	IDUITE TO CA	LICE OF DEAT						(`			YES 2 NO
AN	DID TOBACCO USE CONTR	IBUIE 10 CA					UNCE	RTAIN	<u> </u>			
PHYSICIAN: MEDICAL	EXAMINER?	HOSPITAL:			OTHER	t:						
₹	1 YES 2 NO 27. MANNER OF DEATH	1 Inpatiant 2 28a. DATE OF			-			Idenca	6 Other (Specify)			
	1/Natural 5 Pending	(Month, D		28b. TIM INJ	URY	28c. INJU WOF	RK?		26d. DESCRIBE HOW I	NJURY OCC	CURED	
B	Accident Investigation	20a BLACE O	E IN HUEV ALL				ES 2 🗌	NO				
입	3 Suicide 8 Could not be 4 Homicide determined	building,	F INJURY — Al hor etc. (Specify)	ne, ierm, i	Rreet, lact	ory, offica			28f. LOCATION (Street and City or Town, State)	and Number	or Rural Ro	sute Number,
	29a. CERTIFIER					_						
COMPLETED	(Check only 1 CERTIFYING PHYSIC								to the cause(a) end mar			
8	XX MEDICAL EXAMINER	: Un the Meele of a	camination and/or is	nveatigatio	n, in my o	pinion, de	ath occure	d at the	time, date end place, an	d dua to th	e cause(a)	and manner as stated.
BE	296 SIGNATURE AND TITLE OF CERTIFIER	1	1.	111	1		29c. LICEN	SE NUM	IBER	29d. OATE	SIGNEO ((Month, Day, Year)
2	1 laur	103	re	WY	1		0.	C.N	1.E. DEC	EMBI	ER 6	, 1994
- 1	3 NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	SE OF DEATH STEN	1 27) (Supe	(Defeat)							

31 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DEC1 4 1994

32. REGISTRAR'S SIGNATURE Diwdlor Randell,

Penn Street, Baltimore, Maryland 21201



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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

PRISIDIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

The certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Memai Hygiene prior to burial, cremation, or removal. TO THE HOSPITAL OF THE MULTIPLE THE LAW REQUISES that the death certificate be executed within 24 hours after death. Page 6 may be retained by the bosp TO THE FUNERAL DIRECTION After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours and director, page 5 should be detached be filed within 72 hours and director, page 5 should be detached be filed within 72 hours and director and the filed between the marked, at Item 23 is marked, at Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND ME CERTIFICATE OF DEATH		HYGIENE REG. NO.
CEDENT'S NAME (First, Middle, Last)	2	2. DATE OF	F DEATH

	1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF I	DEATH
	Emma J. Mitchell Dec 09 94	M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) Country)	or Foreign
	212-28-2392 II M 2 RF 84 YRS. MONTHS DAYS HOURS MIN. Jun 20 10 Country) VA	
	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH	
DIRECTOR	Bayview Medical Center Baltimore City	
2	RESIDENCE OF DECEDENT	
E C	III. INSTE	
	MD ————— Ba; timore City 1 🙊 vs 2 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTE	
FUNERAL	201 47 77 1	***
N.	201 N. Washington Street 21231 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No — 14. RACE — American	Indian
	1 Never Merried 2 Merried FORCES? 1 YES 2 ND II yes, specify Cuben, Mexican, Puerto Rican, etc.) Black, White, etc.	moren,
BY	3 🔯 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 TYES 2 🗷 NO Specify: Specify: Blace	: k
9	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	
	Elementary/Secondary (0-12) College (1-4 or 5 +) life. Do NOT use retired.)	
MP	7 Domestic-Cook Private Homes	
COMPLETED	17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname)	
B	James Walton Sarah Brown	
0	19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
	Margaret M. Brooks 5818 Edge Park Rd. Apt B Balto, MD 212	139
	20g, METHOD OF DISPOSITION 1 \(\text{LS Burlet} \) 2 \(\text{C remetion} \) 3 \(\text{Removal from State} \) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	
	4 Donestion 5 Onher (Specify) Baltimore Cemetery 12/14/94 Baltimore, Mī)
	THE PITE RESIDENT	
	Unity Funeral Home 108 W. North Av. Balto, MD 21201	
	23 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approx	ximate il Batwean
	The case of the second	and Daath
- 1	disesse or condition resulting in deeth) . Congusting Heart Lailing	
	Sequentially list conditions. Ongestury Heart failure Onset On	
NO	Sequentially list conditions, Due review Say any few School (March 1) And Consciousness of the conditions of the condi	
CERTIFICATION	If any, laading to immediate cause. Enter UNDERLYING	
윤	CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):	
E	resulting in death) LAST	
DICAL	PART II. Other significent conditions contributing to death but not reculting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? AMILABLE PR	IDR TO
ă	1 YES 2 DAO COMPLETION DF GEATH?	DF CAUSE
ž	1 TES 2	□ NO
A N	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check capty case)	
PHYSICIAN: ME	EXAMMER? HOSPITAL: OTHER:	
14S	1 YES 2 W NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 286. DATE OF INJURY 28b. TIME OF 26c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED	
	27. MANNER OF DEATH 286. DATE OF INJURY 286. DATE OF INJURY (Month, Day, Year) 286. TIME OF INJURY WORK? M 1 YES 2 NO	- 1
B	2 Accident investigation 28e PLACE OF INJURY - At home farm street lendous office.	
	4 Homicide determined building, etc. (Specify) building, etc. (Specify) City or Town, State)	ĺ
91	20e. CERTIFIER	
COMPLETED	296. CEHIFIER (Check only one) 2 SETIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner se stated,	
8	2 MEDICAL EXAMINER: On the beete of examination end/or investigation, in my opinion, death occured at the lime, date and place, and due to the cause(a) and menner	ae stated.
핆	296. SIGNATURE AND TITLE OF CERTIFIER 296. DATE SIGNED (Month, Day, V	ear)
5	of NAME AND ADDRESS OF BEDOOD WAS COMPLETED CAUSE OF DESIGNATION	
	MELITUM. TORRESMO 441 S. ELLWOOD AVE BALTO, MO 21224	
	DEC1 4 1994 July Deutler Parks Signature	
1		- 1

This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

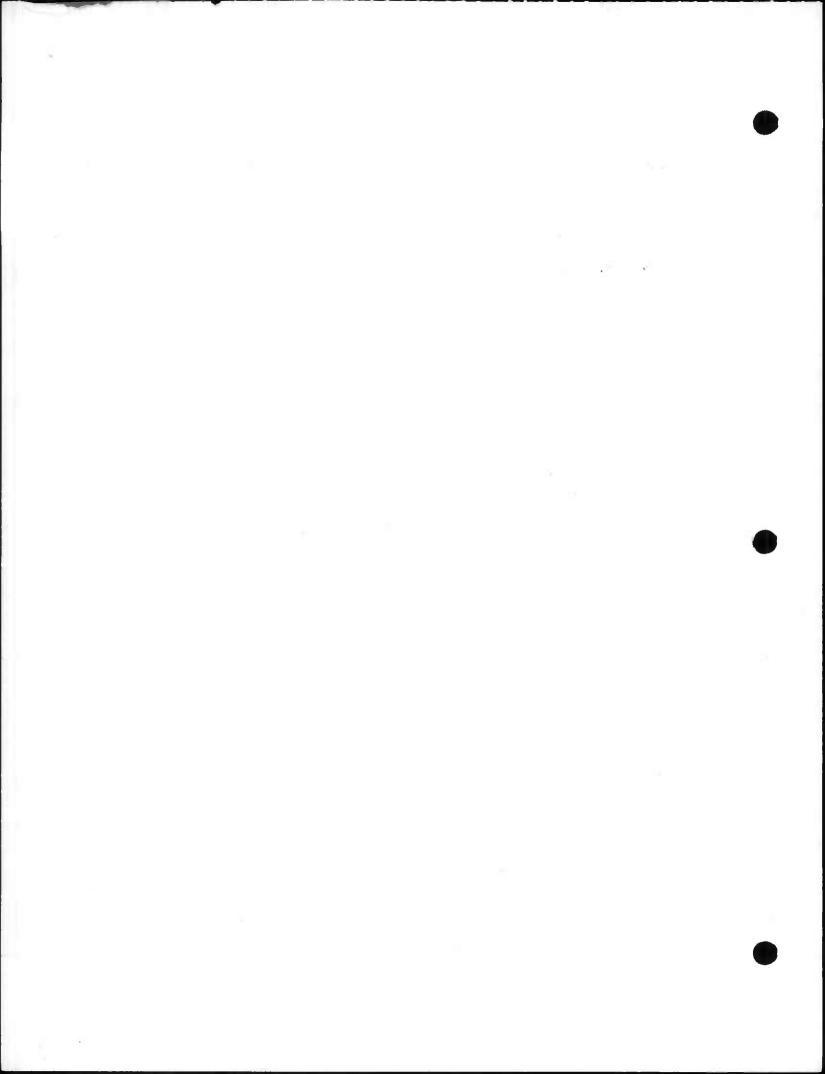
marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020
TO THE HOSPIT	TO THE HOSPITE OF ATENDING PHYSICIAN: The law requires that the death certificate be executed within a nouns after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNER	TO THE FLANER LIGHTER AND THE CONTINUES AND THE CONTINUES AND THE FLANER LIGHTER LIGHTER AND THE FLANER LIGHTER LIGHTER AND THE FLANER LIGHTER LIGHTER LIGHTER L
be filed within 7	be first within A locals and wen the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: II	IMPORTANT: If new 22th marked, or litem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE C	F DEATH		REG. NO.	_		
	1. DECEDENT'S NAME (First, Middle, Last)						ATE OF DEATH			3. TIME OF DEATH
	OLIE	MARTI	N			CEMBER '		YEAR 1994	м	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH					1 – 1		PLACE (State or Foreign	
	2204002===	1 M M 2 □ F	71 YRS.	MONTHS DAY	S HOURS M	IN (A	fonth, Day, Year)	100	Countr	γ)
	230189355 9e. FACILITY NAME (If not institution, give s	med and numbers	/ 1	01 01TH T01			LY 6, 19			IRGINIA
œ	4			96. CITY, TOV	N OR LOCATION	OF OEATH		9c. COU	NTY OF D	EATH
0	1903 ASTER RO	DAO		ROS	EOALE				BA	LTIMORE
DIRECTOR	10e, STATE 10b, COUNTY	,	10c CI	ry, TOWN OR LO	CATION					10d, INSIDE CITY
E	LAG BAI	_TIMORE	227						- 1	LIMITS?
	MD BAL	- I TIMOUE		DSEDALE						t 🗌 YES 2 🔙 NO
¥.					10f. ZIP CODE			10g. CIT	IZEN OF V	YHAT COUNTRY?
FUNERAL	1903 ASTER ROAD				21237			US	SA	
5	11. MARITAL STATUS	12. WAS DECEDENT EVER FORCES? 1 M YE					IGIN? (Specify Yes	or No-	14. RACE	— American Indian, , White, atc.
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR OR			, specify Cuban, M YES 2 NO S		rto Hican, atc.)		Speci	
	3 Wildowed 4 Divorced	WW II								WHITE
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18a. DECEDENT'S	USUAL OCCUP	ATION most of working		18b. KIND OF BUS	INESS/IN	DUSTRY	
91	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT L	se retired.)	most or working					
鱼	8	0	SHIPYA	7D			STEEL	_		
ō	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER	S NAME (FI	rst, Middle, Maiden	Sumame)		
	OLIE MAR	RTIN			1.11	A C	ARTER			
BE	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	AOORESS (Stre			Yumber, City or Town	n Stata Zir	n Codel	
임	GLENDORA MARTIN			3 ASTER			ALE, MAF			227
	20a. METHOD OF DISPOSITION		0b. PLACE AND DATE			7			City or To	
	1 Burial 2 Cremation 3 Ram	oval from State	emetery, cremetory or o	other place)		1	Alex I			
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE 2TO	ENEFE		ANEY VA				TIML	DRE,	MO
		200			E AND ADDRESS (2.6.1		
	1 Jenus /c	. Killy					LE FUNER			
	23. PART I. Enter the diseeses, or o	omplications that caus	ed the deeth. Do	not enter the	mode of dying.	such as	cardiac or resol	ratory er	rest.	Approximate
	shock, or heart fallure.	List only one ceuse on	eech line.							Interval Bstween
	IMMEDIATE CAUSE (Finel disease or condition	m1.	1-0	+7	10-	-				Onset and Death
- 1	resulting in death)	B. Myscs Dyle to (OR AS	race		farel	cos				Munition
		DIE TO (OH AS	A CONSEQUENCE ((F):	1					
CERTIFICATION	Sequentially list conditions,	o. ONM	CONSEQUENCE C	ery 6	Usles	e .				years
AŢ	if sny, leading to immediate cause. Enter UNDERLYING	00L 10 (011 AL	7 CONSEGUENCE C	·).						
5	CAUSE (Disease or Injury	DUE TO (OR AS	A CONSEQUENCE O	6 .						
Ē	that initiated events resulting in deeth) LAST	502 10 (011 A	A CONSCOULAGE O	τ).						
<u> </u>		d								
ابد	PART II. Other significant condition	s contributing to deeth	but not resulting	In the underl	Ing ceuse give	n In Part I	. 24a. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
DICAL							PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
9	-						1 TYES 2	□ NO		OF DEATH?
2	DID TODA GGO LIGE GOVER									1 WES 2 NO
ž I	DID TOBACCO USE CONTI	RIBUTE TO CAUSE				TAIN L]			
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEA	TH (Check only o	ne)					
	1 TYES 2 AND	1 Inpatient 2 ER/O	rtpetlent 3 🗆 DOA	4 Nursing I	iome 5 Areside	nce 6 🗆 C	Other (Specify)			
XS		28s. OATE OF INJUR		IE OF 28c.	INJURY AT WORK?	28d.	OESCRIBE HOW II	JURY OC	CUREO	
PHYS	27, MANNER OF OEATH	(Month, Day, Year								
3Y PHYSICIAN:	1 Natural 5 Pending	(Month, Day, Year	IN.	M 1	YES 2 NO)				
B	1 Natural 5 Pending 2 Accident Investigation 3 Suicide a Could not be	28s. PLACE OF INJU	RY At home, term,			281.	LOCATION (Street a	nd Number	or Rural R	oute Number,
B	1 Natural 5 Pending 2 Accident Investigation		RY At home, term,			281.	LOCATION (Street a City or Town, State)	nd Number	r or Rural A	oute Number,
B	1 Natural 5 Pending Investigation 3 Suicide a Could not be determined	28a. PLACE OF INJU building, atc. (S)	RY — At home, term, ec/ly)	street, factory, o	ffice	281.	City or Town, State)			oute Number,
B	1 Natural 5 Pending Investigation 3 Suicide 4 Homicide a Could not be detarmined 29e. CERTIFIER (Check only)	28s. PLACE OF INJU- building, stc. (S)	RY — At home, term, ec/ly) wledge, death occurr	street, factory, o	ffice	28f.	City or Town, State)	ner as ata	ted.	
	1 Natural 2 Accident 3 Suicide 4 Hemicide 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	28a. PLACE OF INJU- building, stc. (S) CIAN: To the best of my knd R: On the best of axaminat	RY — At home, term, ec/ly) wledge, death occurr	street, factory, o	ffice	28f.	City or Town, State)	ner as ata	ted.	
COMPLETED BY	1 Natural 5 Pending Investigation 3 Suicide 4 Homicide a Could not be detarmined 29e. CERTIFIER (Check only)	28a. PLACE OF INJU- building, stc. (S) CIAN: To the best of my knd R: On the best of axaminat	RY — At home, term, ec/ly) wledge, death occurr	street, factory, o	ffice	28f.	City or Town, State)	ner as ata	ted, ne cause(s)	
BE COMPLETED BY	1 Natural 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 298. SIGNATURE AND TITLE OF CERTIFIER	28a. PLACE OF INJU building, stc. (S) CIAN: To the best of my kno R: On the bests of axaminst	RY — At home, term, eccly) wledge, death occurrion and/or investigate	street, factory, o	ffice late and piece, and n, death occured a	28f.	City or Town, State)	ner as ata	ted, ne cause(s)	and manner as stated.
COMPLETED BY	1 Natural 2 Accident 3 Suicide 4 Hemicide 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINE	28a. PLACE OF INJU building, stc. (S) CIAN: To the best of my kno R: On the bests of axaminst	RY — At home, term, eccly) wledge, death occurrion and/or investigate	street, factory, o	lete and place, and no death occurred a 29c. LtCENSE	due to the time, of NUMBER	cause(a) and man	ner as atai d due to the 29d, OAT	ted, ne cause(s)	and manner as stated.
BE COMPLETED BY	1 Natural 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 30. NAME AND ADDRESS OF PERSON WHY 9/057 Frankly	28a. PLACE OF INJU building, stc. (%) CIAN: To the best of my kno. R: On the best of axaminate of the best of axaminate of the best of axaminate of the best of axaminate of the best of axaminate of the best of axaminate of the best of axaminate of the best of axaminate of the best	RY — At home, term, ecrity) wiedge, death occurrion and/or investigate for (ITEM 27) (Type Druce	street, factory, o	lete and place, and no death occurred a 29c. LtCENSE	due to the time, of NUMBER	City or Town, State)	ner as atai d due to the 29d, OAT	ted, ne cause(s)	and manner as stated.
BE COMPLETED BY	1 Natural 2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE 298. SIGNATURE AND TITLE OF CERTIFIER	28a. PLACE OF INJU building, stc. (S) CIAN: To the best of my kno R: On the bests of axaminst	AY — At home, term, eccly) wiedge, death occurring and/or investigation	street, factory, o	lete and place, and no death occurred a 29c. LtCENSE	due to the time, of NUMBER	cause(a) and man	ner as atai d due to the 29d, OAT	ted, ne cause(s)	and manner as stated.





DIVISION OF VITAL RECORDS, P.O. BOX 687604

TO THE HOSP OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within or hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNE ALL PHEATLE After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within or nours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT Name 28-1s marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR				F DEATH	REG. NO	_		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	AY Y	3. TIME OF DEATH	
	EVA PEAR 4. SOCIAL SECURITY NUMBER 5. S						94 M		
		SEX 6. A	AGE (In yrs. last birthday)	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)	
	220 14 J40/A	- 25	85 YRS.			7-11-1909		Maryland	
DIRECTOR	99. FACILITY NAME (If not institution, give street of St. Joseph Hospi			Towso:	N OR LOCATION OF D	EATH	Balt	timore	
E C	10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LO	CATION			10d. INSIDE CITY	
	Maryland Baltim	ore		Towson	-111.50			LIMITS?	
FUNERAL	100. STREET AND NUMBER 111 West Roa	d			21204			OF WHAT COUNTRY?	
B≼	1 Never Merried 2 Merried	WAS DECEDENT EVI FORCES? 1 1 1 IF YES, GIVE WAR O	YES 2 X NO	II yes	DECENDENT OF HISPA specify Cuben, Maxico (ES 2 NO Specific		or No — 14.	RACE — American Indian, Black, White, etc. Specify: White	
	15. DECEDENT'S EDUCATIO (Specify only highest grade comp		18e. DECEDENT'S	USUAL OCCUP	ATION	16b, KIND OF BUS	SINESS/INDUS	TRY	
51		llege (1-4 or 5+)	life. Do NOT u	se retired.)	most or working				
MPI	UNKNOWN		Homen	axer		Owr	n Home		
COMPLETED	17. FATHER'S NAME (First, Middle, Last) UNKNOWN	Z	amzow		18. MOTHER'S NA	ME (First, Middle, Maiden		ertson	
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAJLING	ADDRESS (Stre	et and Number or Rural	Route Number, City or Tow	n. State. Zip Co	ide)	
5	Georgia P. Nugent							re, Md. 21234	
	20e. METHOD OF DISPOSITION 1							y or Yown, State Maryland 21204	
	21. SIGNATURE OF FUNERAL SERVICE LICENSE				AND ADDRESS OF FA			-	
	*Wallace S	· Broo	Seen.	Rucl	Towson H	Tuneral Hom Towson, M	ne, Inc	20.4	
CERTIFICATION	23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or reapiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):								
CERT	eauting in death) LAST a thew & destre disease by								
MEDICAL	PART II. Other eignificant conditions contributing to death but not recuiting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMAILBLE PRIOR TO COMPLETION OF CAUSE DE DEATH? 1 YES 2 NO								
ż	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN								
0	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	SPITAL:	26. PLACE OF DEA	TH (Check only of OTHER:	ne)				
PHYSICIAN:			Outpatient 3 DOA		lome 5 🗆 Residence	8 Other (Specify)			
ВУ РН	27. MANNER OF BEATH Return 5 Pending 2 Accident Investigation	(Month, Day, Ye	er) 26b. TIN	URY	INJURY AT WORK? YES 2 NO	28d. DEŞCRIBE HOW II	NJURY OCCUR	ED	
	3 Suicide 6 Could not be determined	28a. PLACE OF INJ building, etc. (URY — At home, farm, (Specify)	streat, factory, o	ffica	281. LOCATION (Street e City or Town, State)	and Number or I	Rural Route Number,	
COMPLETED	29s. CERTIFYING PHYSICIAN:							euse(e) and manner ee stated.	
BEC	295. SIGNATURE AND TITLE OF CERTIFIER		plac:		29c LICENSE NU	WBER C	29d. DATE SI	IGNED (Month, Day, Year)	
임	30. WAME AND ADDRESS OF PERSON WHO CO	MPLETED CAUSE D	DEATH (ITEM 27) (Type	Print)	10-1	76	- (713199	
	Dr. Marcelino All	/			•			,	
31. DATE FILED/MON. DOS Julia Di RECOSTRARI DIGNATURE									

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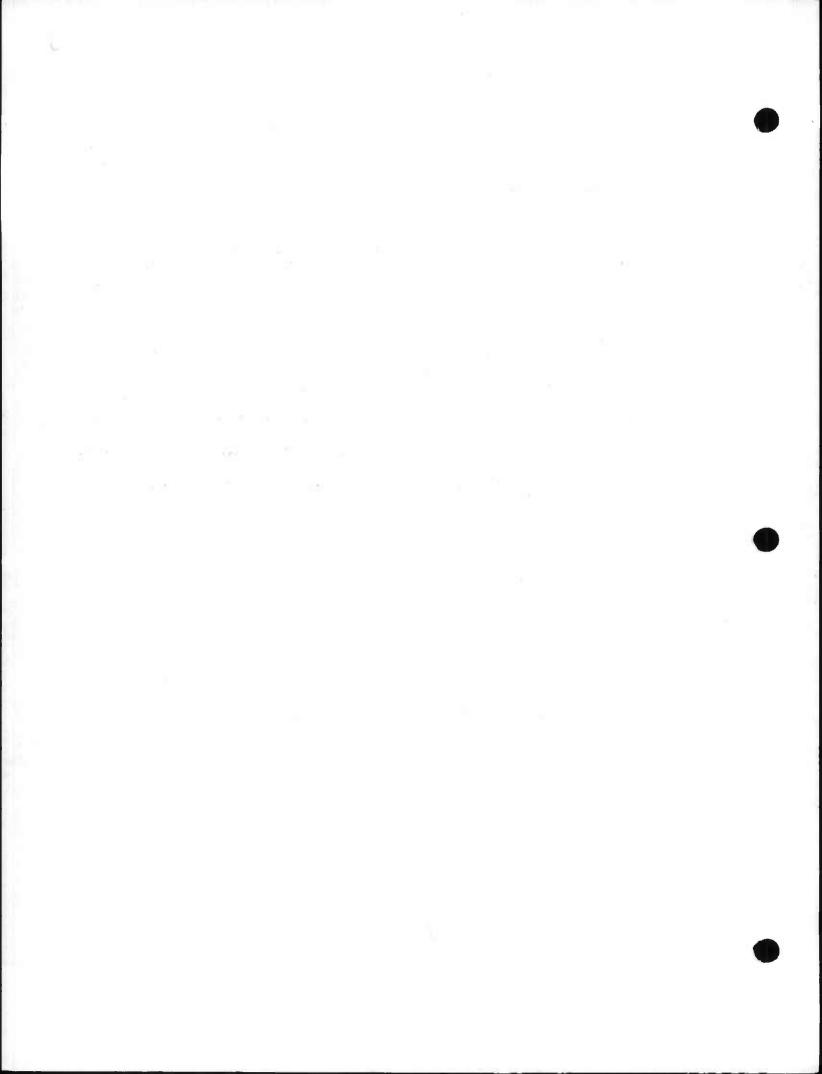
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WENTING PHYSICIAN: The law requires that the death certificate be executed with the found after the formal physician.

The confiction has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be the control of the first permit. Pages 1, 2, 3 should be the control of the first permit. Pages 1, 2, 3 should be the control of the first permit. Pages 1, 2, 3 should be the control of the control

FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.										
11	1. DECEDENT'S NAME (First, Middle, Last) ROBERT OWEN					2. DATE OF OEATH MONTH		YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. les	at birthday	T I BIOCE A UCAN		15	11	94		
9	212-44-8849 1 □ × 2 □ F	50 50		MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year, APR. 18,	1944	PHOE	IPLACE (State or Foreign ny) NIX, MD	
DIRECTOR	9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITA RESIDENCE OF DECEMENT	96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY 9c. COUNTY OF DEATH								
ដ្ឋ	10a. STATE 10b. COUNTY		10c, CITY	TOWN OR LOCAT	ION				10d. INSIDE CITY	
	MARYLAND n//a	n//a		BALTIMORE					1 YES 2 NO	
FUNERAL		STREET AND NUMBER 518 ROBERTS STREET		101. ZIP COOE 21217					ED STATES	
B≼	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	T EVER IN U.S. AR	RMED NO		city Cuban, Maxica	IC ORIGIN? (Specify n, Puarto Rican, etc.)		14, RACI Black Speci	E — American Indian, k, White, atc. ^{//y:} BLACK	
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DE	6a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working			16b. KIND OF BUSINESS/INDUSTRY				
COMPLETED	Elementary/Secondary (0-12) College (1-4 or 5+) 5 TH -		He. Do NOT use retired.) STOCK WORKER			PRODUCE MARKET			Г	
	17. FATHER'S NAME (First, Middle, Last) ROBERT MOALS	16. MOTNER'S NAME (First, Middle, Malden Surname) RUTH OWENS								
9E	19s. INFORMANT'S NAME (Type/Print)	19	b. MAILING	ADDRESS (Street a	nd Number or Rural F	loute Number, City or	Town, State, Zi	(p Code)		
٩	DEBORAH FRANKLIN		518	ROBERTS	STREET	, BALTIMO	ORE, M	1AR Y L	AND 21217	
	20a. METHOD OF DISPOSITION XX Burlal 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify)	20b. PLACE cemetery, cre KING		F DISPOSITION (Ne			LOCATION -			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	- IKING	MILI		D ADDRESS OF FAC		ANDALL	JIOW	ויי, ויוט	
	· Lee V. 36ll	and		WM. C	. MARCH	FH1101	E. N	IORTH	AVENUE	
	23. PART I. Enter the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or reepiratory erreat, ahock, or heert feilure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition								Interval Between Onset and Death	
	resulting in death) a. Seed DUE TO	(OR AS A CONSE	OUENCE OF):					6 months	
S S	Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF):									
ICAT	Trans, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (Disease or Injury								24 hours	
Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
	PART ii. Other significant conditions contributing to	death but not	regulting is	n the underlying	ceuse cluen in	Part I Dec 1980	AM AUTOBOV	Lan	WERE AUTOPSY FINDINGS	
PHYSICIAN: MEDICAL	PART ii. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 0						240	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
ME									1 YES 2 NO	
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)									
SIC	EXAMINER? 1 YES 2 NO 1 Inpatient 2	ER/Outpatient 3	DOA	OTHER:	5 Rasidence					
μ	27. MANNER OF DEATH 28a. DATE OF (Month, D	INJURY	26b. TIME	OF 28c, INJ	JRY AT	26d. DESCRIBE HO	W INJURY OC	CURED		
BY F	1 Natural 5 Pending 2 Accident Investigation		INJURY WORK? 1 YES 2 NO							
	3 Suicide 6 Could not be detarmined 28e. PLACE C building,	F INJURY — At ho atc. (Specify)	ome, ferm, s	treet, factory, offic		281, LOCATION (Str City or Town, St		or or Rural I	Route Number,	
COMPLETED	29a. CERTIFIER (Check only one) 1 **CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and placa, and due to the cause(a) and manner as stated. 2 **MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as stated.									
BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year)									
30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type Print)							1/94			
Glynis A Moody, 70 University of Mayland St Butimere 170 2120/								190/		
	DEC1 4 1994 Julia Diwelso	R'S AGNATURE								



3. TIME OF DEATH 12:15PM

10d. INSIDE CITY

STATES

14. RACE - American Indian, Black, White, etc.

BLACK

21214

Approximata

WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO

COMPLETION DE CAUSE

1 YES 2 NO

OF DEATH?

29d. DATE SIGNED (Month, Day, Year)

1/2

Interval Batween

Onset and Death

1XXYES 2 NO

8. BIRTHPLACE (State or Foreign

, MARYLAND 21215-0	
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BALTIMORE,	
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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, La

Se. FACILITY NAME (If not institution, give

5 SEY

1 - M 2 F

A SOCIAL SECURITY NUMBER

211-18-0063

DECT 4 1994

80 DIVISION OF VITAL RECORDS, P.O.

DIRECTOR Pages 1, 2, 3 CHURCH HOME HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT 10b. COUNTY 10c CITY TOWN OR LOCATION MARYLAND BALTIMORE permit. FUNERAL 10a, STREET AND NUMBER 10f. ZIP COOF 1434 AISQUITH burial-transit STREET 21202 attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THOU IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 TES 2 NO Specify: BY 3 Widowed 4 Divorced use as the 15. DECEDENT'S EDUCATION ETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Specify only high hospital or ò Elementary/Secondary (0-12) College (1-4 or 5+) COMPL TH be detached ABORER-URBAN SERVICES once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Melder Surname the 7 3 BE JOSEPH TRUSTY SARAH page 5 should notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street end Number or Pural Route Number, City or Town, State, Zip Code) 2 JOAN KELLY FREEDOM WAY WEST, BALTIMORE, MARYLAND pe 20e. METHOD OF DISPOSITION
1 Suriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE must funeral director, ARBUTUS MEMORIAL PARK 12-16 Donetion 5 - Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY WM, C. MARCH FH.-1101 E. NORTH AVENUE the medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, illed in by shock, or heart failure. List only one cause on each line. 6 IMMEDIATE CAUSE (Final the cremation, disease or condition resulting in death) METASTATIC C DUE TO (OR AS A CONSEQUENCE OF): GASTRIC CANCER and completely to burial, cremation event. traumatic CERTIFICATION Sequentially list conditions, 2 QUE TO (OR AS A CONSEQUENCE OF) attending physician a if any, leading to immediate cause. Enter UNDERLYING death certificate be CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in death) LAST 0 signed by the atter Health and Mental PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL any shows been to of h PHYSICIAN: has b 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate I **EXAMINER?** HOSPITAL: OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) 1 YES 2 NO 1 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c marked, INJURY 1 Netural 5 Pending Investigation M 1 YES 2 NO BY After 2 Accident DIRECTOR: A hours after de tem 28 is n 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 🔲 Homicide HOSPITAL DR 29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner as atsted. FUNERAL within 72 h 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1 29c. LICENSE NUMBER BE or Zemi 017322 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SONATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS.

9b. CITY, TOWN OR LOCATION OF DEATH

6. AGE (In yrs. last birthday)

YRS.

80

94	3	7	i	9	9
-				_	-

MARYLAND

10g. CITIZEN OF WHAT COUNTRY?

BALTIMORE

20c. LOCATION - City or Town, State

ARBUTUS, MARYLAND

9c. COUNTY OF DEATH

n/a

UNITED

16b. KIND OF BUSINESS/INDUSTRY

CITY OF

24a. WAS AN AUTOPSY PERFORMED?

1 YES 2 NO

BOULDIN

REG. NO.

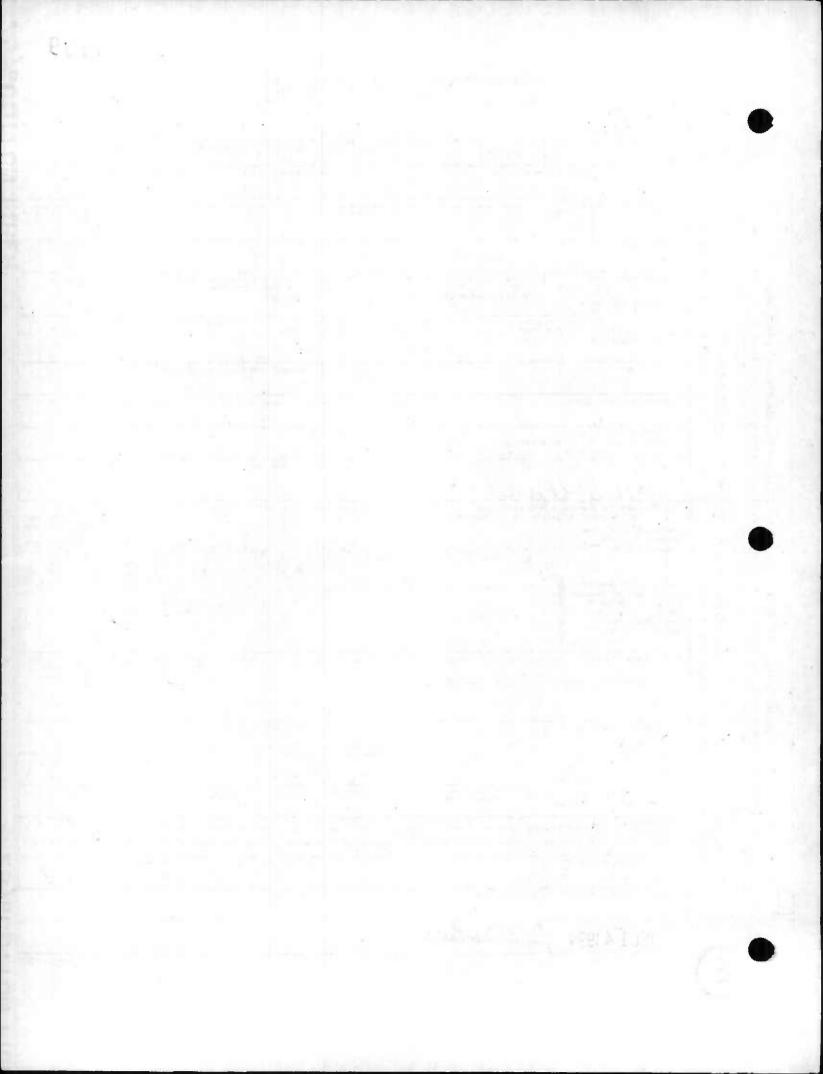
1914

2. DATE OF DEATH

7. DATE OF BIRTH

DEC. 2,

DHMH-16 Rev 1/89



NATENDING PHYSICIAN: The law requires that the death certificate be executed within after death. Page 6 may be retained by the hospital or attending physician.

Office of the state has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be attended for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
CERTIFICATE OF DEATH	REG. NO.

		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	D / DEPAR	RTMENT O	F HEA	LTH AND I	MENTAL HYGIEN	E	
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH		3. TIME OF DEATH
	9.	Alberta Janice	Pfeffer					Dec. 12.	"1994 ["]	7:00 a. M
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BI							BIRTHPLACE (State or Foreign Country)	
- 1		210-20-12/1	□ M 2 🗓 F 64	YRS.	MONTHS D	AYS HO	OURS MIN.	May 9, 19	30	Maryland
_	.	9s. FACILITY NAME (If not institution, give street			9b. CITY, TO	WN OR LO	OCATION OF DE	ATH	9c. COUNTY	OF DEATH
DIRECTOR		4247 Sheldon Avenu	ie		Balt	imor	e		N/A	
1 1		10e. STATE 10b. COUNTY		10c, CIT	Y, TOWN OR L	OCATION	-			10d. INSIDE CITY
=		Maryland N/A		Ba	ltimor	e				LIMITS?
4		10e. STREET AND NUMBER				10f. ZIP	CODE		10g. CITIZEI	N OF WNAT COUNTRY?
FUNERAL		4247 Sheldon Avenu	ıe			21	206		U.S.	Α.
1 5			2. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2	S. ARMED	13. WAS	DECEND	ENT OF HISPAN	IC ORIGIN? (Specify Yes	or No 14	. RACE — American Indian, Black, White, etc.
E A		1 Never Married 2 Married 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DATES				NO Specify	n, Puerlo Ricen, etc.)		Specify:
ED	- 41	15. DECEDENT'S EDUCATI	TION 16	a. DECEDENT'S	1 0000	IBAT4ON	-	201		White
		(Specify only highest grade con	mpleted)	(Give kind of a	work done during	ng most of	working	16b. KIND OF BUS	SINESS/INDUS	ТНҮ
٦		9th	College (1-4 or 5 +)	Opera	tor			Telen	hone C	Company
ONCE.		17. FATHER'S NAME (First, Middle, Last)		opera		18.	MOTHER'S NAI	ME (First, Middle, Maiden		ompany
E at	Ш	Henry G. Pfeffer,	Sr.				Alber	ta Krieg		
TO B		19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (S	treet and N		loute Number, City or Town	n, State, Zip Co	ode)
E -		Henry G. Pfeffer J	r. (Brother)	3229	Kenyo	n Av	enue,	Baltimore	, Md.	21213
ts		20a, METHOD OF DISPOSITION 1 🔀 Burlal 2 🗌 Cremation 3 🗍 Removal		ACE AND DATE		N (Name o	of	DATE 20c. LO		
E		4 Donation 5 Other (Specify)	0a	k Lawn	Cemet				<u>ltimor</u>	e, Maryland
Ē		21. SIGNATURE OF PUNERAL SERVICE LICEN	7				nek Fun	eral Home		
		want						ane, Balti		
or other traumatic event, the medical examiner must be notified at once. TO BE COM		23. PART I. Enter the diseasea, or com ahock, or heart failure. List	nplications that caused the tonly one cause on each	e death. Do i	not enter the	mode D	of dying, auch	n aa cardiac or reapi	ratory arreal	t, Approximate interval Batween
		IMMEDIATE CAUSE (Final Onset and Death								
Ę,		disease or condition reaulting in death) a. Small bound abstruction / Yo								
2		disease or condition resulting in death) a. Set boul stanta / Yo DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
		Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):								
arl A		if any, landing to immediate cause. Enter UNDERLYING								
		CAUSE (Disease or injury that initiated events	DUE TO (DR AS A CO	NSEQUENCE OF	n.					1400
ry, or other traumatic		resulting in death) LAST								
Injury,		PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS								
	1	PERFORMED? AMALABLE PRIOR TO COMMENTE STORY OF CAMES								
ध्रा 🎹			81					1 YES 2	-NO	OF DEATH?
S Show		DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF D	DEATH YE	S \square NC	Пι	JNCERTAIN			1 TES 2 NO
PHYSICIAN:	h	25. WAS CASE REFERRED TO MEDICAL	26. 1	PLACE OF DEAT			JI TOLKIT WI	, ,		l
marked, or item BY PHYSICI			IOSPITAL: Inpetient 2 ER/Outpetier	nt 3 🗆 DOA	OTHER: 4 Nursing	Home 5	- Masidenca	B ☐ Other (Specify)		
F 16	1	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28	. INJURY .	AT	28d. DESCRIBE HOW II	NJURY OCCUR	RED
mark BY	ľ	1 Netural 5 Pending 2 Accident Investigation			M 1	YES	2 NO			
		3 Suicide a Could not be determined	28a. PLACE OF INJURY — A building, etc. (Specify)	At home, ferm, i	street, factory,	offica		28f. LOCATION (Street a City or Yown, State)	nd Number or	Rural Route Number,
ET ET	ı									126
<u> </u>			N: To the best of my knowledge							
COMPLETED		2 MEDICAL EXAMINER: C	On the beals of exemination and	d/or investigatio	n, in my opini	on, death	occured at the	time, data and place, and	d due to the c	ause(a) and manner as stated.
E		296. SIGNATURE AND TITLE OF CERTIFIER	1-	2		29c	LICENSE NUM		29d. DATE SI	IGNED (Month, Day, Year)
TO BE		30. NAME AND ADDRESS OF PERSON WHO CO	A Bu				1) (60	4(P /	2/11/54
		Dr. Authur Serpick,				Ma	21204	C+ T	mb ! - T	In and had
	ŀ	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATUI		owson,	. DIT	21204	, at. Jose	hu.e F	iospital
			Davidson Randall	-						ì
	_ L									

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permit. Pages 1, 2, 3 should

									94	3	7201	
3	Item1, g-718, 12-1 FOR STATE REGISTRAR	4-94,perf.h.,dr STATE OF MAR				HEALTH AND F DEATH			E			
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH								YEAR	3. TIME OF DEAT	тн	
	4. SOCIAL SECURITY NUMBER 216-09-4967	1 🗌 M 2 💢 F	GE (In yrs. lest		IF UNDER 1 YEAR	HOURS MIN.	7. DATE OF B (Month, De) June 10	y, Year)	17	8. BIRTHE Country Mary		oreign
TOR	99. FACILITY NAME (# not institution, Hopkins Bayviet RESIDENCE OF DECEDEN		ter		Baltin	n or location of d	EATH		N/A	NTY OF DE	HTA	
DIRECTOR	Maryland N/A	A			town or Local						10d. INSIDE CITY LIMITS? 1 X YES 2	
FUNERAL	4504 Willshire					21206			U.	S.A.	HAT COUNTRY?	
EU FU	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O	ES 2 X N		It yes,	ECENDENT OF HISPA specify Cuben, Mexic ES 2 NO Speci	en, Puerto Rican		or No—	14. RACE Black, Specify	- American Indi White, etc. White	en,
-	15. DECEDENT'S (Specify only highest Elementary/Secondary (0-12)	S EDUCATION I grade completed) College (1-4 or 5+)	(Gh	re kind of wi Do NOT use		TION most of working			INESS/IND	DUSTRY		_
COMPL	17. FATHER'S NAME (First, Middle, Last Julius Broczkay] но	memal	ker	18. MOTHER'S NA	AME (First, Middle		Surname)			
TO BE	Julius Broczkawska Catherine Gutowski 190. INFORMANT'S NAME (Type/Print) Walter K. Pupa (Husband) 4504 Willshire Avenue, baltimore, Md. 21206											
	20a, METHOD OF DISPOSITION 1 N Burlel 2 Cremetton 3 4 Donation 8 Other (Specify))	20b. PLACE A	ND DATE O	FDISPOSITION per place) Slaus	Name of Cemetery	12/15	20c. LOC	ATION —	City or Tow	rn, State	d
	21. SIGNATURE OF FUNERAL SERVICE	- Carl	tno	h	Sch: 3331	and address of fall munek Fur Brehms 1	neral H Lane, B	alti	more	, Md.	21213	
	23. PART I. Enter the diseases shock, or heert fell IMMEDIATE CAUSE (Finel disease or condition resulting in death)	Myocardia	al Inf	arcti	ion	node of dying, suc	ch es cerdiac	or respir	etory arr	est,	Approximinaterysi B Onset and 24hr	etween d Desth
TION	DUE TO (OR AS A CONSEQUENCE OF): Sequentially liet conditions, if sny, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):											
RTIFICATION	CAUSE. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events resulting in death) LAST											
SICAL CE	PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PRIORINGS PERFORMED? 1 X YES 2 NO COMPLETION OF CAUSE											
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
YSICI	25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 X NO	HOSPITAL:			I (Check only or OTHER: I Nursing H	ome 5 🗆 Residence	8 Other (Spe	ncify)				
В	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investige	(Month, Day, Yea	28b. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY AT WORK? 1 YES 2 NO 28c. PLACE OF INJURY — At home, farm, street, tectory, office				28d. DESCRIB					
ETED.	3 Suicide 8 Could not be datermined 28. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Inc. (Specify) 281. LOCATION (Street and Number or Rural Route Inc. (Specify) 281. LOCATION (Street and Number or Rural Route Inc. (Specify) 282. LOCATION (Street and Number or Rural Route Inc. (Specify) 283. LOCATION (Street and Number or Rural Route Inc. (Specify) 284. LOCATION (Specify) 284. LOCATION (Specify) 284. LOCATION (Specify) 284. LOCATION (Specify) 284. LOCATION (Specify) 284. LOCATION (Specify) 284. LOCATION (Specify) 284. LOCATION (Specify) 284. LOCATION (Specify) 284. LO							ute Numoer,				
COMPLET	one) 2 MEDICAL EXA	PHYSICIAN: To the best of my kr AMINER: On the bests of examina									end <i>m</i> enner es s	tated.
296. SIGNATURE AND TITLE OF CERTIFIER							MBER		29d. DATE	E SIGNED (Month, Day, Yeer)	

L1404

CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF PERSON WHO COMPL

Paul V. Johns Hopkins Bayview Medical Center O'Donnell,

31. DATE FILED (Month, Pey, 16/1994

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DIVISION OF VITAL	
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		1 - FOR STATE OF MARYLAND C		OF HEALTH AND I	MENTAL HYGIENE REG. NO.	Ē
		1. DECEDENT'S NAME (First, Middle, Last)		- OI BEAILI	2. DATE OF DEATH	3. TIME OF DEATH
			EISINGE	R	MONTH / 13	1 12:55 pm m
		4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. In	MONTHS	1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	?. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
Pin		212-07-3181 1 □ x м 2 □ F 87	YRS.		Oct. 21,19	07 Maryland
3 should	Œ	9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital	9b. CITY	town or location of de Baltimore	ATH	9c. COUNTY OF DEATH
.2	СТОВ	RESIDENCE OF DECEDENT				
Pages	DIRE	100. STATE 100. COUNTY Maryland Baltimore	10c. CITY, TOWN	ntonsville	-	10d. INSIDE CITY LIMITS?
permit.	AL D	10e, STREET AND NUMBER		· 101, ZIP CODE		1 ☐ YES 2 🙀 NO
	E	461 Whitfield Road		21228	,	10g. CITIZEN OF WHAT COUNTRY? U.S.A.
-0020 ing physician. the burial-transit	FUN	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. A	RMED 13.	WAS DECENDENT OF HISPAN	IIC ORIGIN? (Specify Yee	or No- 14. RACE American Indian,
0 DD2	BY F	1 Never Married 2 Merried FORCES? 1 YES 2 FIF YES, GIVE WAR OR DATES		II yes, specify Cuben, Mexice 1 TES 2 NO Specify		Black, White, etc. Specify:
ದ ಕ್ಷಿ	0	A -	ECEDENT'S USUAL O	CCUBATION	465 KIND OF BUO	White
T. 8 C	ETE	(Specify only highest grade completed) (Give kind of work done is. Do NOT use retired.)	during most of working	16b. KIND OF BUSI	INESS/INDUSTRY
O a B	COMPL		Projectio	nist	Movie T	Theaters
4 9 9 E	00	17. FATHER'S NAME (First, Middle, Last)			ME (First, Middle, Maiden S	
ed by	BE	William Henry Reisinger 190. INFORMANT'S NAME (Type/Print)			elle Hender	
MAR retained 5 should notified	2			S (Street end Number or Rural P COLM Circle		lle Maryland 21930
May be or, page		20e. METHOD OF DISPOSITION	AND DATE OF DISPOS			CATION — City or Town, State
Fe 6		1 → Burlel 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) □ LOUGO	ematory or other place) n Park Ce	emetery 12/16	6/94 Balt	imore Maryland
ALTIM death. Page funeral direct.		21. SIGNATURE OF PURITIES SERVICE LICENSEE		NAME AND ADDRESS OF FA		zke Funeral Homes
BALT ter death. the funera wal.		Lusses and Lake		_		atonsville Maryland
dours after and in by the or removal		23. PART i. Entar tha diseases, or complications that caused the d shock, or heart failure. List only one cause on each lin	eath. Do not anter	tha mode of dying, auci	as cardiac or respir	ratory arrest, Approximata
	- 1	IMMEDIATE CAUSE (Final		2 0 4	1 00	interval Between Onset and Death
d within ompletely fill cremation.	1	disease or condition resulting in death) a. Acute Myo	cardial	Infarche	n (anjerio	r Infaret) 6 days
B 6 - 6	7	DOE TO (ON AS A CONSE	OUENCE OF):	,		
OX 68 be execut sician and c rior to buri traumatic	RTIFICATION	Sequentially llat conditiona, if any, leading to immediate DUE TO (OR AS A CONSE	OUENCE OF):			
cate b ohysicii e prior	CA	cause. Enter UNDERLYING CAUSE (Disease or Injury				
death certificate attending physiental Hygiene pri		that initiated events DUE TO (OR AS A CONSE	OUENCE OF):			
	빙	d				
2 2 2 2	SAL	PART II. Other significant conditions contributing to death but not	reaulting in the ur		Part I. 24s. WAS AN A PERFORM	AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
	MEDIC	Intracerebral hereorhage. old	cerebral.	and become	1 D YES 2	The state of the s
S 0 0 0 0		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA		NO X UNCERTAIN		1 TYES ZY NO
Sep as a	¥	25. WAS CASE REFERRED TO MEDICAL 28. PLA	CE OF DEATH (Check			
	PHYSICIAN	1 YES 2 NO HOSPITAL:	OTHEI	R: sing Home 5 🗌 Residence	8 Other (Specify)	
TENDING PHYSICIAN: OR: After this certifical fler death with the St is marked, or it	H.	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW IN	JURY OCCURED
After the death	B√	2 Accident Investigation	M M	1 YES 2 NO	AM 1004701 (0)	
TENOR IS	圓	3 Suicide 8 Could not be 4 Homicide determined	Alle, terrin, street, tact	ory, onice	City or Town, State)	nd Number or Rural Route Number,
HO 27	ZET	29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, di	eath occurred at the I	ms date and place, and due	to the cause(s) and mann	Par an etelad
2 2 2 3 8 2 3 5	COMPL	(Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or				
THE TO Filed	BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	. 1	29c. LICENSE NUM	BER	29d. DATE SIGNED (Month, Day, Year)
TO THE De filed	0 0	Commanyth pro. Re	sident	D-44	789	12/13/94
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITE	M 27) (Type, Print)	Or Agues Has	P 900 CATO	NAVE, BALTO, MD 21229
		31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	DICIVE, C	TI DENOZ 1103	1 100 91101	1,470,
		DEC1 4 1994 Julis Davidson Randall				

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the brospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	REGISTRAR		CEF	RTIFIC	CATE OF	DEATH	RI	EG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last) JAMES	Α.	SMI				2. DATE OF D DECEMB	ER 11	, 1994	3. TIME OF DEATH 12:25 P _M
	4. SOCIAL SECURITY NUMBER 219-28-8275	1 🕅 M 2 🗆 F	GE (In yrs. lest bit		IF UNDER 1 YEAR HONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF B (Month, Day 10/4)	/32	Counto	Lto., Md
DIRECTOR	99. FACILITY NAME (If not institution, give s THE JOHNS HOPKIN RESIDENCE OF DECEDENT				BALTIN	OR LOCATION OF D		90	c. COUNTY OF DE	EATH
	10a. STATE 10b. COUNT	Y	1	Oc. CITY,	TOWN OR LOCAT	ION		_		10d. INSIDE CITY
LOIR	Maryland 10o. STREET AND NUMBER			I	Baltime	zip CODE				LIMITS? YES 2 NO
FUNERAL	1607 Normal Av					21213			g. CITIZEN OF W	1
B	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVIFORCES? 1 K N	er in U.S. Armei res 2 no or dates 1/9/5		if yes, sp	ENDENT OF HISPA ecify Cuben, Mexica NO Specia	an, Puerto Rican	ecify Yes or f , etc.)	No- 14. RACE Black Specif	— American Indian, , White, atc. y: Black
	15. DECEDENT'S EDU (Specify only highest grade	CATION	18e. DECE	DENT'S U	SUAL OCCUPATION	ON	16b. KINI	OF BUSINE	SS/INDUSTRY	
COMPLETED	Elementary/Secondary (0-12) 12th	College (1-4 or 5+)	life. Do	NOT use	rk done during mo retired.)	st of working	Fra	ank S	erio	
BE CON	17. FATHER'S NAME (First, Middle, Last) Harry Smith					18. MOTHER'S NA				
	19e. INFORMANT'S NAME (Type/Print)		19b. M	AILING A	DDRESS (Street a	nd Number or Rural	Route Number, Ci	ity or Town, St	are, Zip Code)	
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	20e. METHOD OF DISPOSITION Burlel 2 Cremation 3 Ram 4 Donetton Other (Specify)		Complety, Cremat	DIY UT OUT	or place!	me of 12/1 t Vet.			ON - City or Tow	vn, State
	21. SIGNATURE OF FUNERAL SERVICE LIC		ott		LERO	O. DY	ETT &			AL HOME 21207
	23. PART A. Enter the diseases, Dr	complications that car	sed the death	. Do no	t entar the mo	da of dying, suc	h sa cardiec	or respirato	ry arrest.	Approximata
	shock, or heart failure.	e. ARRAY	neech iine.			,,,,,		or reapmate	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Interval Batween Onset and Deeth
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- 11	PART ii. Other eignificent condition	a contributing to dee	th but not resu	ilting in	the underlying	ceuse given in	Part i 24s	WAS AN AUT	neev 24h	WERE AUTOPSY FINDINGS
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	27. MANNER OF DEATH	28a. DATE OF INJU		Bb. TIME			28d. DESCRIB		SY OCCURED	
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- 11	29b. SIGNATURE AND TITLE OF CERTIFIER	ł	·			29c. LICENSE NUI	MBER	290	d. DATE SIGNED	
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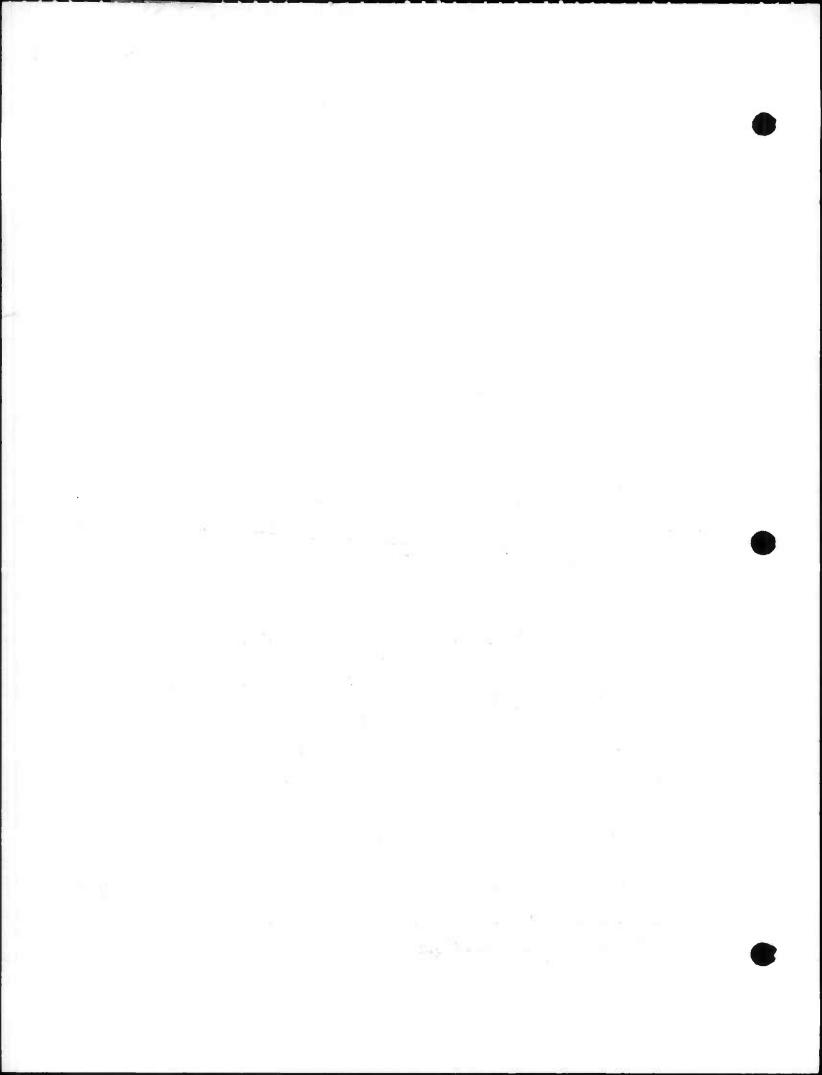
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within explores fler death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SHELTON D. SADLER 4. SOCIAL SECURITY MAMEER 1.94 = 20 - 6.874 SCH MOTION FUNCTION OF LOCATION OF DEATH Social SECURITY MAMEER (if not institution, pive siteme and number) Social SECURITY MAMEER (if not institution, pive siteme and number) Social SECURITY MAMEER (if not institution, pive siteme and number) Social SECURITY MAMEER (if not institution, pive siteme and number) Social SECURITY MAMEER (if not institution, pive siteme and number) Social SECURITY MAMEER (if not institution, pive siteme and number) Social SECURITY MAMEER (if not institution, pive siteme and number) Social SECURITY MAMEER (if not institution, pive siteme and number) Social SECURITY MAMEER (if not institution, pive siteme and number) Social SECURITY MAMEER (if not institution, pive sitemed and number) Social SECURITY MAMEER (if not institution, pive sitemed and number of numbers) Social SECURITY MAMEER (if not institution, pive sitemed and numbers) Social SECURITY MAMEER (if not institution, pive sitemed and numbers) Social SECURITY MAMEER (if not institution, pive sitemed and numbers) Social SECURITY MAMEER (if not institution, pive sitemed and numbers) Social SECURITY MAMEER (if not institution, pive sitemed and number of numbers) Social SECURITY MAMEER (if not institution, pive sitemed and number of numbers) Social SECURITY MAMEER (if not institution, pive sitemed and number of numbers) Social SECURITY MAMEER (if not institution, pive sitemed and number of numbers) Social SECURITY MAMEER (if not institution, pive sitemed and number of numbers) Social SECURITY MAMEER (if not institution, pive sitemed and number of numbers) Social SECURITY MAMEER (if not institution, pive sitemed and number of numbers) Social SECURITY MAMEER (if not institution, pive sitemed and number of numbers) Social SECURITY MAMEER (if not institution, pive sitemed and number of numbers) Social SECURITY MAMEER (if not institution) Social SECURITY MAMEER (if not institution) Social SECURITY MAMEER (if not		1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
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LA UCUI 47994 Julia Davelson Karlall	1/1	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S S	IGNATURE							
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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DECEMBER 11, 1994 ANNA M STEINER 0355 AM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign (Month, Day, Year) 4-26-20 216-18 -6266 1 M 2 F 74 YRS. Maryland 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Lutherville t YES 2 XNO FUNERAL 10a, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1215 Malbay Dr. 21093 U.S.A. 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—
If yes, specify Cuben, Mexicen, Puerto Rican, stc.) 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Merried Specify: 1 YES 2 K NO Specify ΒY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) Payroll Manager American Standard 17. FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Stonewall Jackson Steiner ĕ Anna Mae Miller BE notified 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ruth C. Snow 14111 Manor Rd. Baldwin, Md. 21013 pe 20a, METHOD OF DISPOSITION
1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must Loudon Park Cemetery 12-14 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY examiner Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 medical 23. PART t. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, abock, or heart fellura. List only one ceuse on each line. Approximata Interval Between IMMEDIATE CAUSE (Finel **Onset and Death** the disease or condition moraremma mi reaulting in death) event, traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any 1 YES 2 NO OF DEATH? Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES PHYSICIAN: NO X 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) HOSPITAL:
1 kinpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO 4 Nursing Name 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATN 28e. DATE OF INJURY 26c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 60 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Nomicide item 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner se stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) and menner so stated. TO THE HOSPITA
TO THE FUNERA
De filed within 7
IMPORTANT: 1 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE 950 WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 10W MD GERARD IMMIUM Md

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BALTIMORE, MARYLAND 21215-0020

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31. DATE FILED (Month, Day, Year)

32. REGISTRAR'S SIGNATURE

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 500 A Rhoda В Sauer 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Month, Day, Year)
(NOV. 22,1906 213-20-8422 1 M 2 TF DAYS. HOURS 88 Nov. Maryland leath. Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Lorien Nursing Home DIRECTOR Columbia Howard RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY IDc. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? Maryland Baltimore 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? 3358 Strickland Street 21229 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puarto Rican, etc.)

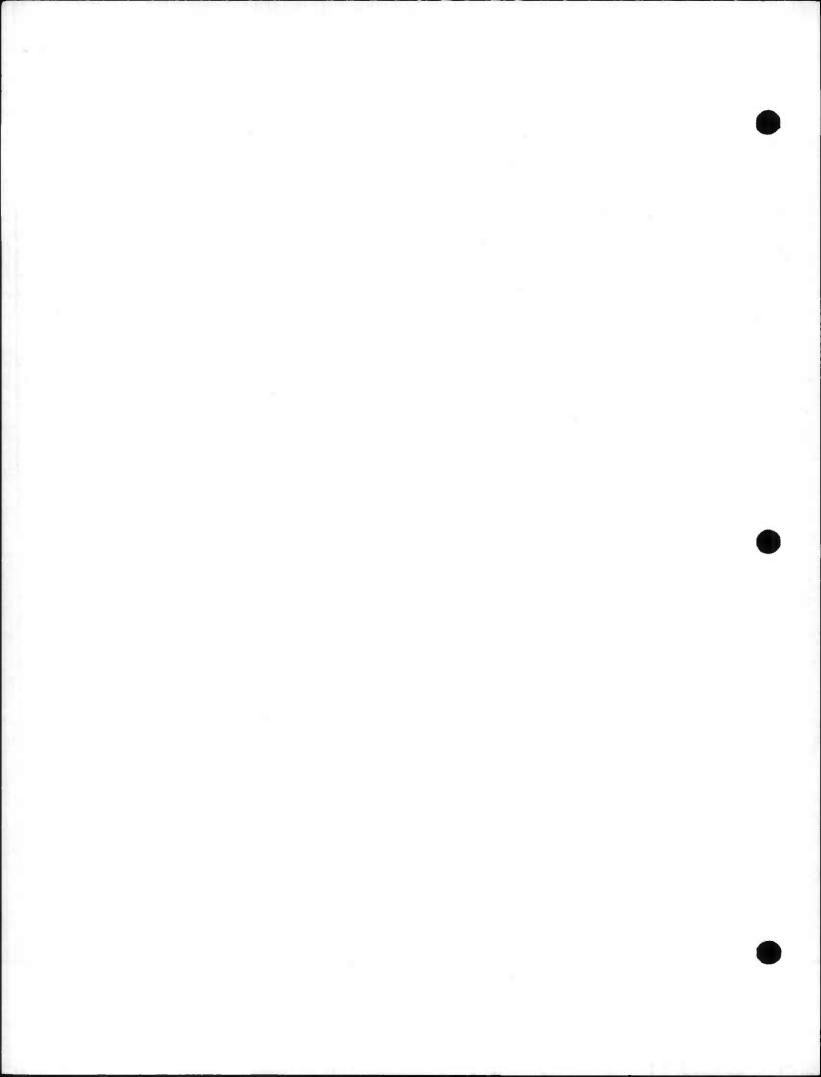
1 YES 2 NO Specify: 1 Never Married 2 Married BY Specify: 3 ₩ Widowed 4 Divorced White 16a. DECEDENT'S USUAL OCCUPATION

10a bind of work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Dorsey Warthen BE Isabelle Ogle 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Marlyn Welsh (Daughter) 231 Worthmont Road Catonsville Maryland pe 20e. METHOD OF DISPOSITION
1 X Burtal 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Nama of DATE 20c. LOCATION — City or Town, State must cametery, crematory or other place)

Loudon Park Cemetery 12–15–94 Donation 5 Other (Specify) Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSES examiner 22. NAME AND ADDRESS OF FACILITY nours after death. Leroy M & Russell C Witzke Funeral Homes in by the for 1630 Edmondson Avenue Catonsville Maryland medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, completely filled in by Approximata Interval Between ahock, or heart fellure. List only one cause cremation, or **Onset and Death** IMMEDIATE CAUSE (Final the - mobable Alzheiner's disease or condition resulting in death) lementra event. executed with DUE TO (OR AS A CONSEQUENCE OF) hysician and com traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): attending physician a ental Hygiene prior to certificate be ceuse. Enter UNDERLYING CAUSE (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 the death signed by the atter Health and Mental Inlury. PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? blood that any noemine 1 YES 2 NO requires Shows 1 YES 2 NO ŏ DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES Dept. NO 23 this certificate has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The State HOSPITAL: OTHER:
4 M Nursing Homa 5 Residence 8 Other (Specify) 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 6 the 27. MANNER OF DEATH 28a. DATE OF INJURY 28h TIME OF 28c. INJURY AT 28d. DEŞCRIBE HOW INJURY OCCURED marked, with 1 Natural 2 Accident INJURY 5 Pending M 1 YES 2 NO BY After death Investigation DIRECTOR: A Yours after de 18 28 18 F 3 Sulcide 28s. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town State) 8 Could not be PLETED 4 Homicide 29a. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. S 29b. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day Year) BE 9 RSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) UBE7 Aunapolis Rd Ellicott

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

DHMH-18 Rev 1/89



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DIVISION OF VILAL RECORDS, P.O. BOX 68/60,	HE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within yours after death. Page 6 may be retained	TO CHAIRDREN PROPERTY. ALSO AND AND AND AND AND AND AND AND AND AND
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burla-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burla, certainly or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA		ENT OF HEALTH AND	MENTAL HYGIEI							
	1. DECEOENT'S NAME (First, Middle, Last)	~			2. DATE OF DEATH	-/2 0.5	3. TIME OF DEATH					
	Victoria	{ ` }.	Tysie	wicz	Dec. 8	B, 1994 **	1:30 A M					
	4. SOCIAL SECURITY NUMBER		THPLACE (State or Foreign									
	215 64 9343 10 M 280 F 72 YRS. MONTHS DAYS HOURS MIN. FLO. 27 1922 PUSET											
DIRECTOR	PARYLAND (STURRAL HOSPITAL BALTIMORS) RESIDENCE OF DECEDENT 96. COUNTY OF DEATH 96. COUNTY OF DEATH											
EC	RESIDENCE OF DECEDENT											
ä	mapylon Rot	MORE	PORK	2/1/2			10d. INSIDE CITY LIMITS?					
	10e. STREET AND NUMBER	11.1010		10f, ZIP CODE		100 CITIZEN OF	1 TYES 2 NO					
FUNERAL	about soon I	Ans		21771	1	11 0						
S		12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Y	e or No — 14. RA	CE - American Indian					
	1 Never Married 2 Married	FORCES? 1 YES		If yes, specify Cuban, Maxic 1 ☐ YES 2* NO Speci	an, Puerto Rican, atc.)	Bio	CE — American Indian, ack, White, etc. acify:					
ВУ	3 Widowed 4 Divorced			7 120 2 Jac 100 3530	.,,.	Ü	J.H.T3					
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade of	ATION ompleted)	18a, DECEOENT'S USUA (Give kind of work d	L OCCUPATION one during most of working	16b. KINO OF BU	JSINESS/INOUSTRY						
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use retir	ed.)			- 1					
MP	layrs.		HTA	smo								
8	17. FATHER'S NAME (First, Middle, Last)	1-		18. MOTHER'S N.	AME (First, Middle, Maide	Surname)	4 = .					
H	GEORGE MIC	Kas		GIOR	GIAMA	GRIFFI	774					
2	190. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDI	RESS (Street end Number or Rural	Route Number, City or To	wn, State, Zip Code)	, 21236					
	SYEUN HILOTAL	DAOO	12 Likes	WALL LOURI	PIRRY	IALL I'IF	AYLAND					
- 1	20e. METHOD OF DISPOSITION 1 M Buriel 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Cremetory or other place) CARCION ARYLAN											
	4 Donation 5 Other (Specify)		ARRIJON									
	110014			22. NAME AND ADDRESS OF F	TTOEUTU	loRisi.						
		S.m. D		8800 HARF	180 KORO	-MARK	ellis					
	23. PART I. Enter the diseases, or co shock, or heart fellure. Li	implications that caused	the deeth. Do not en	nter the mode of dying, suc	ch as cerdiac or resp	piratory erreet,	Approximate					
	IMMEDIATE CAUSE (Finel	st only one cause on es	cri une.				Interval Between Onset and Death					
	disesse or condition resulting in death) Pneumonia											
ĺ	DUE TO (OR AS A CONSEDUENCE OF):											
Z	Sequentially list conditions,											
Ĭ	bequentially list conditions, but to (or as a consequence of): If any, leading to immediate cause. Enter UNDERLYING											
일	CAUSE (Diseese or injury C.	OHE TO (OR AS A	CONSEQUENCE OF):									
Ē	that initiated events resulting in death) LAST	OUE TO (ON AS A C	CONSEDUENCE OF):				i					
CERTIFICATION	d.											
AL	PART II. Other significant conditions	contributing to deeth bu	t not resulting in the	underlying ceuse given in		N AUTOPSY 24	4b. WERE AUTOPSY FINOINGS					
5			AVAILABLE PRIOR TO COMPLETION OF CAUSE									
Ä		_			1 TYES	X	DF DEATH?					
ž	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
BY PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	2	6. PLACE OF DEATH (Ch									
is	1 D YES 2 D	HOSPITAL:	tlant 3 DOA 4 D	HER: Nursing Home 5 - Residence	8 Other (Specify)							
E	27. MANNER OF OEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?	28d. OESCRIBE HOW	INJURY OCCUREO						
≥	1 Natural 5 Pending 2 Accident Investigation		1	1 YES 2 NO								
	3 Suicide 8 Could not be	28a. PLACE OF INJURY - building, atc. (Specifi	At home, farm, street,	tactory, office	281. LOCATION (Street City or Town, State	end Number or Rura	l Route Number,					
COMPLETED	4 Homicide detarmined											
7				he time, data and place, end due								
ŏ				my opinion, death occured at the			e(s) end menner es stated.					
	296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU	MBER	29d. DATE SIGNE	ED (Month, Day, Year)					
BE C	1. Genole	esman,	M.D.	892	13	▶ 12-	-08-94					
유	30. NAME AND ADDRESS OF PERSON WHO		, , , , , , , , , , , , , , , , , , , ,									
	Inna Gendel	sman, M.D.	c/o Mar	yland Gener	al Hospi	tal						
	Inna Gendel 31. DATE FILED (MORIT) Pay, 40-21 994	34 REGISTRAR SIGN	VIGE ATT									
l li	DECY & 1294	American manager										

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FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR		CI	ERTIF	ICATE OF	DEATH	REG. NO					
	1. DECEDENT'S NAME (First, Middle, Last)					527(111	2. DATE OF OEATH			3. TIME OF OEATH	_	
	Frank J. Vanci	ura					December	12.10	YEAR	4:00 A.	м	
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. les	st birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH			IPLACE (State or Foreign	_	
	217-18-3993	1 X M 2 □ F	94	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year)	- 1	Country	TY)	,,	
	9a. FACILITY NAME (If not institution, give s	street and number)	7 7		Ob CITY TOWAL	DE LOCATION OF D	Dec. 11,			ryland		
Œ	1911 Philadel-ti- P 1											
70	RESIDENCE OF DECEDENT	La RUAU			Jo	рра			Harf	ord		
DIRECTOR	10a. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN OR LOCA	TION			$\overline{}$	10d. INSIDE CITY		
H	Maryland Bai	ltimore			Ft	. Howard				LIMITS?		
7	10e. STREET AND NUMBER					. ZIP CODE		10- CITIZ	ZEN OF V	1 YES 2 X NO		
FUNERAL	9220 Todd Ave	niie			1.0	21052			.S.A			
N.	11. MARITAL STATUS	12. WAS OECEDEN	T EVED IN ILE AD	MED	140 400 050							
	1X Never Married 2 Married	FORCES? 1	YES 2 N	40	II yes, sp	ecify Cuban, Maxico	NIC ORIGIN? (Specify Ye nn, Puarto Rican, etc.)	a or No-	14. RACE Black	E — American Indian, k, Whita, etc.		
ВУ	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES		1 🗆 YES	2 NO Specif	У		Speck	White		
	15. DECEDENT'S EDU	CATION	16a DF	CEDENT'S	USUAL OCCUPATION	OM .	16b. KIND OF BU	SINESS/INDI	LICTOV	WHITEC		
1	(Specify only highest grade	completed)	(G	ive kind of a	work done during mo	est of working	IOD. KIND OF BU	SINESS/INU	JOINT			
2	Elementary/Secondary (0-12)	College (1-4 or 5 +	•)	N/A	,		Raltim	ore C	ount	y Govt.		
BE COMPLETED	17. FATHER'S NAME (First, Middle, Last)			,					June	y GOVE.		
Ö	Frank Vancura	1					ME (First, Middle, Malder					
BE								kols			_	
2	19a. INFORMANT'S NAME (Type/Print) Charles C Vancu						Route Number, City or Tov					
711			-				l., Joppa,					
	20a, METHOD OF DISPOSITION VARurial 2 Cremation 3 Ram	oval from State	20b. PLACE / cemetery, cre	AND DATE (OF DISPOSITION (Na	ame of	1	CATION — C	-			
	4 Donation 5 Other (Specify)		Most	Holy	Redeeme		12/15 Ba	ltimo	re,	Maryland		
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		_0		D ADDRESS OF FA	ciuty neral Home:	. T	_			
	→ Eugene	V. Car	lno	4	9705	Belair I	Rd., Balti	nore	MD.	21236		
	23. PART i. Enter the disesses, or	empilcations that	t caused the de	ath. Do r	not enter the mo	de of dying, aud	h as cardiac or reap	Iretory arre	est.	Approximate	_	
	ahock, or heert failure.	List only one ceu	se on each iine).					Anii	interval Between		
	IMMEDIATE CAUSE (Final disease or condition CAN R MAN C. A.C. A.C. A.C. A.C. A.C. A.C. A.C.											
- 1	resulting in death) 8. OUR AS A CONSEQUENCE DEL											
_	disease or condition recuiting in death) 8. AUTHOR JUST AND AS A CONSEQUENCE (PF): THE TO GOR AS A CONSEQUENCE (PF): THE TO GOR AS A CONSEQUENCE (PF): THE TO GOR AS A CONSEQUENCE (PF): THE TO GOR AS A CONSEQUENCE (PF):											
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CERTIFICATION	recuiting in death) LAST											
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	PART ii. Other eignificant condition	s contributing to	death but not r	ecuiting	in the underlyin	g ceuse given in	Pert i. 24a. WAS AN PERFO		24b.	WERE AUTOPSY FINDIN	IGS	
DICAL	- Almal	2 bull	alim				1 TYES	4		COMPLETION OF CAUSE OF DEATH?	E	
ш							/ /			1 YES 2 NO		
ä	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	TH YE	S NO [UNCERTAI	N M		1			
Ν	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				TH (Check only one)							
Sic	1 Tes 2 No	HOSPITAL: 1 Inpatient 2	ER/Outpetient 3	□ DOA	OTHER: 4 Nursing Hom	a 5 XBesidence	8 Other (Specify)					
PHYSICIAN: M	27. MANNER OF DEATH	28a. DATE OF	INJURY	28b. TIM	E OF 28c. INJ	URY AT	28d. DESCRIBE HOW	INJURY OCC	URED			
	1 Netural 5 Pending	(Month, Di	ay, Year)	INJ		RK? YES 2 NO						
BY	Accident Investigation	28e. PLACE O	F INJURY — At ho	me, term, a	street, factory, offic		281. LOCATION (Street	and Number of	or Rural F	Inute Number	_	
삗	4 Homicide 8 Could not be	building,	atc. (Specify)				City or Town, State)				
9	29a. CERTIFIER		and with a second	-1 =74	h 9000 22			-117				
₩ M							to the cause(s) and ma					
COMPLETED			umination end/or I	inveatigatio	n, in my opinion, d	eath occured at the	time, date and place, er	nd due to the	/ cause(s)	end manner se stated	d .	
BE (296. SIGNATURE AND TITLE OF CENTIFIED	1	AIV			29c. LICENSE NUI	WBER	29d. DATE	SIGNED	(Month, Day, Year)	_	
2	Jan John	W 1	VI V			1)08	191	DE	·C.	12,1995	L	
F	36. PAME AND ADDRESS OF PERSON WH											
	Dr. Ben Oteyza, 8	346 S. Ma	in St.,	Be1	Air, MD	21014						
	31. DATE FILED (MOTE PL) 1994	32. HEGISTRA	S SIGNATURE	and se								
	DEOT A 1991	1		- Section								

-transit permit. Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within yours after death. Page 5 may be mainted by the artending physician and completely filled in by the funeral director, page 5 should be dised within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at appear. BALTIMORE, MARYLAI DIVISION OF VITAL RECORDS, P.O. BOX 68760,

DHMH-16 Rev 1/89

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USA

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

MARYLAND

EOLU

10d. INSIDE CITY

14. RACE — American Indien, Black, White, atc.

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24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO

1 | YES 2 | NO

COMPLETION OF CAUSE

Interval Between

Onset and Death

12-18 muz

Specify:

WHITE

1 YES 2 NO

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REG. NO

2. DATE OF DEATH

1 - STATE

1. DECEDENT'S NAME (First, Middle, Last)

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Matthias ndol 090 2 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH IF UNDER 24 HRS. 217-16-4185 DAYS HOURS 1 X M 2 - F YRS MAY 14, 1923 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Fallston General DIRECTOR +OSPITO RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION HARFORD FALLSTON Md permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? LAUREL Brook 21047 1900 funeral director, page 5 should be detached for use as the burial-transit after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 1 YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-1 Never Married 2 K Married If yes, specify Cuben, Maxican, Puerto Ricen, atc.)

1 YES 2 NO Specify: BY 3 Widowed 4 Divorced WWI ETED. 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high intary/Secondary (0-12) College (1-4 or 5+) TANK+ PUMP OIL COMPL 12 once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) M. VOGEL MHOL ᅗ B. EARHART ANNA BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 LAUREL Brook Rd, FALLSTON, Md 21047 JOCQUELINE ITEK pe 20a, METHOD OF DISPOSITION

1 Burlai 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 12/54 Timenium, Md INV. Crematory or other place)

VALLEY MEM. Gdns 4 Donation 6 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY EVANS Funeral Chapel Charles 1. 3 NEWPORT DRIVE, Forest anone removal and completely filled in by the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cerdiac or respiratory errest, shock, or haert faliura. List only one cause on each line. 6 IMMEDIATE CAUSE (Finei the disesse or condition recuiting in desth) cremation, LUNG C event. DUE TO (OR AS A CONSEQUENCE DF) executed bunal, omolin traumatic CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 If sny, leading to immediate ceuse. Enter UNDERLYING aftending physician e prior CAUSE (Disease Dr injury or other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST signed by the atter Health and Mental I injury, PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? shows any Health a 1 TES 2 NO peen 50 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO IN UNCERTAIN IN PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE DF DEATH (Check only one) Itеm certificate I HOSPITAL OTHER ATTENDING PHYSICIAN: 1 YES 2 NO 1 Inpetient ER/Outpetient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) the or 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED WITH 28 is marked, this 1 Natural М 1 YES 2 NO BY After death Accident Investigation 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined COMPLETED DIRECTOR: / 4 Homicide -SPITAL FE FUNERAL DIS. VIT. IL ILEM 29 29e. CERTIFIER 1 CERTIFYING PHYSIC AN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated, TO THE HOSPITA
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De filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated, 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 28 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Roy

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4 1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

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MARYLAND 2121

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DIVISION OF VITAL RECORDS, P.O. BOX 68760	DR ATTENDING PHYSICIAN
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1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH BERNICE WILLIAMS DECEMBER 994 12:43 p.M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. OATE OF BIRTH NOV. 4, 1934 IF LINDER 24 HRS. IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 214-26-0209 MONTHS DAYS HOURS 60 YPS GEORGIA 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR THE JOHNS HOPKINS HOSPITAL n/a BALTIMORE CITY RESIDENCE OF DECEDENT 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND n/a BALTIMORE 1 X YES 2 NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? **FEDERAL** 2622 STREET 21213 UNITED STATES 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES X 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No--If yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 11 MADITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried Specific A 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) Щ, Elementary/Secondary (0-12) College (1-4 or 5+) COMPL SCHOOL CROSSING GUARD CITY 11 TH 0F BALTIMORE 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) WILL LITTLE III IF BE MAE JONES 19e. INFORMANT'S NAME (Type/Print) 195 MAILING ADDRESS Federa Rural Route Number, City or Town, State, Zip Code; 2 STEPHEN WILLIAMS 2622 FEDAL STREET BALTIMORE, MD 21213 20e. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION -- City or Town, State Buriel 2 Cremation 3 Removal from State 1 Buriel 2 Cremation 4 Donetton 5 Other (Specify) 12-17 cametery, cremetory or other place) CEMETERY ANNE ARUNDEL CO. MD 21, SIGNATURE OF FUNERAL BETWIE LICENSEE 22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE 23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, Approximata shock, or heart fallure. List only one cause on each line. Interval Batween Onset and Death IMMEDIATE CAUSE (Final disease or condition HSPIRATION PNEUMONIA 3 DAYS resulting in death) DUE TO (OR AS A CONSEQUENCE OF) ANOXIC BRAIN CERTIFICATION Sequentially list conditiona, OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury QUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? MEDICAL 24a. WAS AN AUTOPSY PERFORMED? RENAL FAILURE CIRRHOSIS 1 YES 2 NO 1 TES 2 70 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 - YES 2 -6 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY 28c. INJURY AT 286. TIME OF INJURY 28d, DESCRIBE HOW INJURY OCCURED Natural 5 Pending Investigation t YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be ED 4 Homicide COMPLET 29e. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date end place, end due to the cause(a) and manner ee stated. 2 __ MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(e) end manner ee stated. 296, SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE nomas mo Mollo 12 9 RESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KRLSTI DHOMAS TONER 110 TOHOS HOPKINS MD 32. REGISTRAS SENATURI

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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14. RACE — American Indian, Black, White, atc.

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10g. CITIZEN OF WHAT COUNTRY?

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MARGARET MARIE WEBSTER 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, 4099 70 216 1 M 2 XF DAYS HOURS Dic 30 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed writhin 24 from the formal physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR STELLA MARIS HOSPICS DOWN 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MARYLAND BALLI CAROSY FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 9610 LIXOC 21234 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 NO WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yea, specify Cuban, Maxican, Puarto Rican, atc.)

 T YES 2 NO Specify: 11. MARITAL STATUS FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married BY 35 Widowed 4 Divorced COMPLETED 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) IRK 12×82 1201 CARS+ BLUE CROSS 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surr OHOL BE (1ABITH 19a. INFORMANT'S NAME (Type/Print) 2 20s. METHOD OF DISPOSITION

Burlal 2 Cremation 3 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 19410 CATHEORAI Donation 5 - Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
EVANS CHAPLL OF ME 8800 HARFORD ROAD onter 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Fine) disease or condition resulting in deeth) THRONIC OBSTRUCTIVE LUNGINISEASE DUE TO (OR AS A CONSEQUENCE OF). CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES XI NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: 1 🗆 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. MANNER OF GEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY Natural
Accident 1 YES 2 NO В Investigation 3 Suicide 28a. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 8 Could not be 4 Homicide COMPLET 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

ARKVILLS Approximate Interval Between Onset and Death 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? PERFORMEO? 1 YES 2 NO t YES 2 NO Hospice 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ation and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29d, DATE SIGNED (Month, Day, Year) 21204 **DHMH-16 Ray 1/89**

29c. LICENSE NUMBER

2300 DULANEY VALLEY RD.,

32. Mary Market Carlot

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TOWSON, MD



29b. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILEO (MODECT) 4

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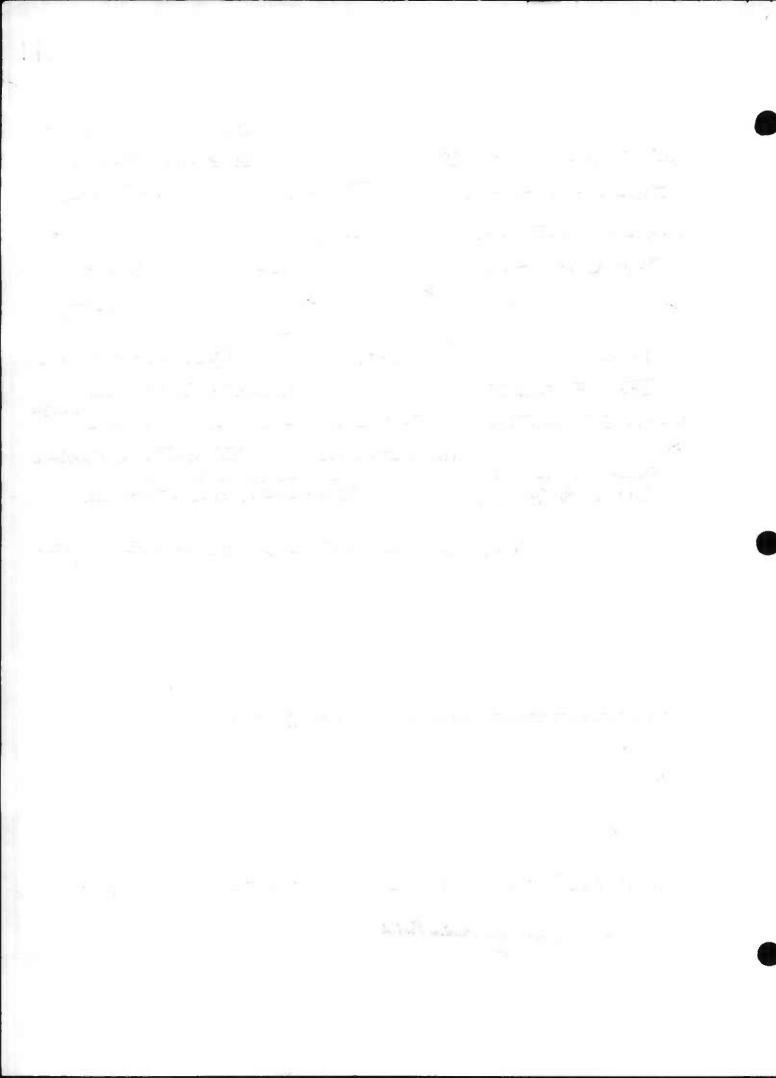
DR. KENDALL FAULKNER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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ALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX

BALTIMORE, MARYLAND 21215-0020	mours after death, Page 6 may be retained by the hospital or attending physician.	als certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the hurist-range narming phase 1.2.3 executed	On, or removal,	se medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 58/60,	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with. The Hospital base is may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fi	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

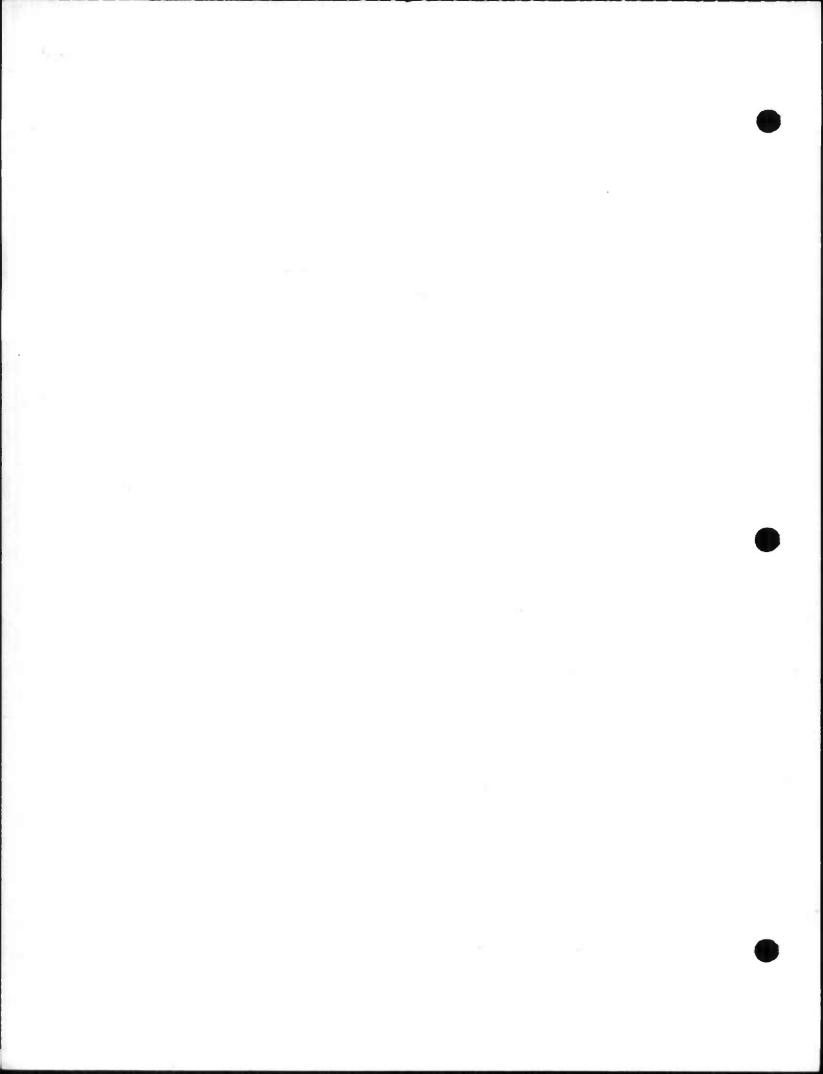
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		Louise W	linga	te								MO		AY 12	GU	3. TIME OF DEATH	
	I	4. SOCIAL SECURITY NUMBE	R	5. SEX	6. AGE (in yrs. lest b	birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.		TE OF BIRTH	10		IPLACE (State or Foreign	
		212-36-9217		1 □ M 2X□ F	88		YRS.	MONTHS	DAYS	HOURS	MIN.	(M	Y 20,19	06	Country	(y)	
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8		MERIDIAN -CA	TON MA	NOR NURS	SING	HOME			BAT.	TIMO	RF						
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	11	17. FATHER'S NAME (First, Mick	dle, Last)										t, Middle, Maiden	,			
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ဥ	- 11	19a. INFORMANT'S NAME (Type											umber, City or Tow	n, State, Zip	Code)		
	-11-	BETTY L. RICH					_				- BA		MORE,	MD	2122		
	- -	1 N Burial 2 Cremation	3 🗌 Ramo	val from State	ceme	PLACE ANI etery, crema	atory or ot	her place)				1			City or Tov	wn, Stata	
	- 10-	21. SIGNATURE OF FUNERAL		INSEE	- 11.0	HDON	PAR		NAME AN				/16 BA	LTIMO	DRE		
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		IMMEDIATE CAUSE (Final disease or condition	1	1.	too					0	15.	4.00		1	. ~		
		resulting in death)		A &	1671	CONSEQUE	100	rot	10	Cas	200	Va-	scular	OU.	suppl		
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3		cause. Enter UNDERLYING CAUSE (Disease or Injury	G														
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EH		resulting in deeth) LAST	d.														
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ED B		3 Suicide 8 Co	ould not be	28a. PLACE OF building, e	INJURY -	At home,	, farm, si	reet, facto	ory, offica			281. LC	CATION (Street a	nd Number	or Rural Ro	oute Number,	
313	L	4 Homicide det	terminad		nei [opocii]							Cit	ly or Town, State)				
PL	2	9a. CERTIFIER 1 CERTIFY	YING PHYSICI	IAN: To the best of n	my knowie	dge, death	occurre	d at the tir	me, data a	nd placa,	and dua	to the c	ause(s) and man	ner as state	ed.		
COMPLET		one) 2 MEDICA	EXAMINER.	On the beals of axr	amination	and/or Inve	atigation	, in my op	olnion, de	ath occure	d at the	time, da	te and place, and	dua to the	cause(s)	and manner as stated.	
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2			M 2½□ F 89	rrs. lest birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mon	OF BIRTH th, Day, Year)		Country)	ACE (State or Foreign
2, 3 should	TOR	98. FACILITY NAME (If not institution, give street at ST. AGNES HOSPITAL	nd number)			OR LOCATION OF D			9c. COUNT		
l. Pages 1,	DIRECTOR	10e. STATE 10b. COUNTY MARYLAND BALT	IMORE	10c. CITY,	TOWN OR LOCA	TION IMORE					d. INSIDE CITY LIMITS? YES 2 1 NO
n. ansit permit.	ERAL	100. STREET AND NUMBER 1237 VOGT AVENUE				f. ZIP CODE 21227					T COUNTRY?
215-0020 attending physician. ise as the burial-transit	BY FUNI	1 Never Merried 2 Merried	MAS DECEDENT EVER IN U. FORCES? 1 YES : F YES, GIVE WAR OR DATE	2 XNO	If yee, sp	CENDENT OF HISPA pecity Cuben, Mexic 5 2 NO Speci	en, Puerto			4. RACE -	American Indian, thite, etc. WHITE
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YLA by the be det	E COMPL	17. FATHER'S NAME (First, Middle, Last) JOHN M. WALPER	DEGREE	171(1	18. MOTHER'S NA		Middle, Malden S	NTAGON Surneme)	1		
MA retain 5 sho	TO BE	100. INFORMANT'S NAME (Type/Print) MR. MILTON C. REIMEI	RS			NUE - BA	Route Nun	nber, City or Town			
R Hay		20a METHOD OF DISPOSITION 1 Duriel 2 Cremetton 3 Removal ft 4 Donation 5 Other (Specify)	com State cometer LOUI	ACE AND DATE OF 19, crematory or oth DON PARI	F DISPOSITION (Na per place) K CEMET1	ame of ERY	12	TE 20c. LOC	ATION — CH		State
death.		21. SHUNATURE OF FUNERAL SERVICE LICENSES	Shann	0	HUBBAI 4107 V	ND ADDRESS OF FA RD FUNER. WILKENS	AL HO AVENI	JE-BALT	IMORE	, MD	21229
within 24 within 24 ppletely fills cremation, went, the		23. PART Fenter the diseases, or complete ahock, or heert tellure. List of the complete and	DUE TO (OR AS A CO	ilne.		ode of dying, aud	ch aa cei	diac or reepir	atory arree	ot,	Approximate Interval Between Onset and Death
certificate be executed ding physician and configure prior to burial, other traumatic et	IFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events Due to (or as a consequence of): Rut Firmul in the occurs in the occurs of the o									322
S, P death e atten lemtal H	CERTIFIC	resulting in death) LAST			1-1-1						
RECORD requires that the peen signed by the t. of Health and M shows any inji	MEDICAL	PART II. Other significant conditions con A with remail for live	cham.	i Brown	L-K:	g cause given in	Part I.	24a. WAS AN A PERFORM 1 YES 2	MED?	CO DF	ERE AUTOPSY FINDINGS AILABLE PRIOR TO IMPLETION OF CAUSE DEATH? YES 2 NO
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T ID FE C	PHYSI	1 VES 2 X NO 1 X	SPITAL: Inpatient 2 ER/Outpatie 28e. DATE OF INJURY	28b. TIME	OF 28c, INJ	ne 5 Residence		or (Specify) SCRIBE HOW IN	JURY OCCU	RED	
ONG PHYS After this death with	ВУ	Netural 5 Pending 2 Accident Investigation	(Month, Day, Year) 28e. PLACE OF INJURY —	A1 home form et	M 1 🗆	PRK? YES 2 NO	204 1 0	2474241 (2)			
OR ATTENDIN OR ATTENDIN DIRECTOR: Aff hours after de	ETED	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Specify)	ATTOMIC, INCIT, AT	eet, includy, offic			CATION (Street ar or Town, State)	id Number or	Hural Houte	Number,
DIV DSPITAL OR A INERAL DIREC Thin 72 hours NT: It Item	COMPLETE	Check only one) 29. CERTIFIER 1 Check only one) 2 MEDICAL EXAMINER: On									d menner ae stated.
TO THE HOSPITAL OF THE FUNERAL DE FILE WITHIN 72 NO 19 PER FILE WITHIN 72 NO 19 PER FILE WITHIN 12 NO 19 PER FILE PER FI	TO BE C	296. SIGNATURE AND TITLE OF CATTIFIER	_			29c. LICENSE NU				GIGNED (MO	onth, Day, Year)
		50. NAME AND ADDRESS OF PERSON WHO COM EDMAND P. TLLD	PLETED CAUSE OF DEATH								
	36		32. REGISTRAR'S SIGNATU	IRE							



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DIVISION OF VITAL RECORDS, P.O. BOX 68760	DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with rhours after death. Page 6 may be retained by the hospital or

215-0020

use as the burial-transit permit. Pages 1, 2, 3 should Þ detached 7 notified be 1 must examiner funeral medical cremation, or traumatic event, the and com prior to other 1 attending phy ntal Hygiene I 6 the atten signed by the any shows has been of h HOSPITAL DR ATTENDING PHYSICIAM: The law in the Name Bulleral DIRECTOR: After this certificate has be within 72 hours after death with the State Dept. 23 10 Is marked, 28

Item

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TO THE HOSPITA
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IMPORTANT: II

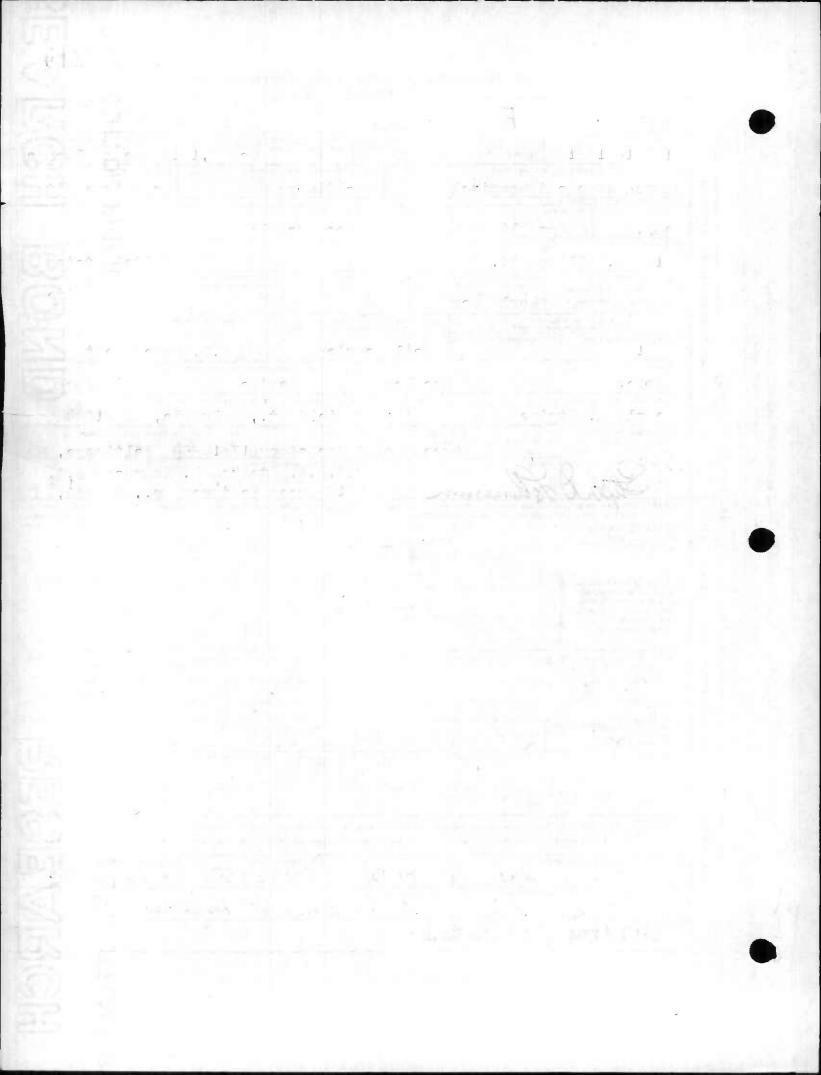
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN 9 YEAR -KANKLIN Wea GLEY 12 3:00 P M 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTN
(Month, Day, Year)
May 9,1912 5. SEX DAYS HOURS 183 10 1661 M 2 | F Pennsylvania Se. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATN DIRECTOR Church Home and Hospital Baltimore Baltimore City RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Penn. Franklin Green Castle 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 147 N. Allison St. United States 11. MARITAL STATUS

Never Merried 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1X YES 2 NO IF YES GIVE WAR OR DATES WORLD WAT II 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuben, Mexican, Puerto Ricen, etc.)

1 YES NO Specify: 14. RACE — American Indian, Black, White, etc. Specify: White BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Mail Carrier U.S. Government 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumeme) Royer Weagley Bertha Finfrock BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Gerald R. Strine 5595 Suffield Ct., Columbia, MD 21044 20e. METNOD OF DISPOSITION
1 Buriel 2 Cremetion 3 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Green Mount Crematory 12/12/94 Baltimore, MD 21. SIGNATURE OF TUNERAL SERVICE C.A.F.A. Stephen D. Lohrmann Towson, MD Jolenann Green Pastures Dr., 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such sa cardisc or respiratory arrest, shock, or haart failure. List only one causa on each lina. Intarval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition SEPSIS resulting in death) DUE TO (OR AS A CONSEQU NCE OF neumonia CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury Dementia DUE TO (OR AS A CONSEQUENCE OF) thet initiated evants resulting in deeth) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

1 YES 2 NO 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Nome 5 ☐ Residence 6 ☐ Other (Specify) 27, MANNER OF GEATN 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. OEȘCRIBE NOW INJURY OCCUREO 1 Natural 5 Pending Investigation BY 1 YES 2 NO 2 Accident 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28t. LOCATION (Street end Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED 4 Nomicide 29e. CERTIFIER 1 CERTIFYING PNYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated, 2 MEDICAL EXAMINER: On the basic of exemination end/or investigation, in my opinion, death occurred at the time, date end place, and due to 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d, DATE SIGNED (Month, Dev. Year) 17323 7 32. REGISTRAR'S SIGNATURE

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		1 - FOR STATE OF MARYLAND C		RTMENT			MENTAL HYGIEN			
	- 1	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	AY	year 3. TIME OF DEATH	
		NATHANTEL H. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. la	of hirthday)	ARRII		ON IF UNDER 24 HRS.	DEC 1	1	94 7:15 P.M	
		226-18-4534 1 M 2 □ F 79	YRS.		-	HOURS MIN.	May 7, 19	15	BIRTHPLACE (State or Foreign Country) N . C .	
pinous		9e. FACILITY NAME (If not institution, give street and number)		9b. CITY, T	OWN OR	LOCATION OF			NTY OF DEATH	
2,	стоя	12 N HILTON STREET		BAL	TIM	ORE C	ITY			
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permit, P.	□	Md 10e. STREET AND NUMBER	Ra	lto					1 X YES 2 NO	
	RA	12 N. Hilton Street			1	O 1 O O O			IZEN OF WHAT COUNTRY?	
020 physician. burial-transit	FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. A	RMED		S DECE		ANIC ORIGIN? (Specify Yes	or No —	14. RACE — American Indian, Black, White, atc.	
LAND 21215-0020 the hospital or attending physician, detached for use as the burial-tran once.	BY F	1 Never Married 2 Married IF YES, GIVE WAR OR DATES	440		YES 2		can, Puarto Rican, atc.) city:		Specify: Black	
r attendil		15. DECEDENT'S EDUCATION (Specify only highest grade completed) (6.0)	ECEDENT'S	USUAL OCC	UPATION		16b. KIND OF BU	SINESS/INC		
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AND the hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S	Gas El		1C	
क दिल्	BE C	John Arrington					Powe11	Gurialina		
retained 5 should notified	10 B						I Route Number, City or Tow	rn, State, Zip	Code)	
ay be r page 5				Edmon of dispositi		Avenu		alto,	Md 21223 City or Town, State	
Page 6 may ral director, p		1 Burtal 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Ce(ar H	i I C	emet	erv			undel Co, Md	
AL IIN death, Pag funeral dii		21. SIGNATURE OF FUNERAL SERVICE LIPENSEE		22, N/	AME AND	F/H W	FACILITY			
ter death. F the funeral oval.		Valo Meuch		4	300	Wabas	h Avenue Ba	ilto,	Md 21215	
ted within 5- hours after death. Page 6 may be completely filled in by the funeral director, page ial, cremation, or removal.		23. PART I. Enter the diseasea, or complications that caused the dishock, or heart failure. List only one cause on each lin IMMEDIATE CAUSE (Final disease or condition resulting in deeth) e. Huge to or as a conse	e.						Intervel Between Onset and Death	
the death certificate be executed the attending physician and coming Mental Hygiene prior to bunal, injury, or other traumatic explanations.	ERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.								
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en ate	SICI	EXAMINER? t \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		OTHER:		s W Basidana	6 Other (Specify)			
F this by	ву рну	27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation	28b. TIN		8c. INJUR	RY AT	28d. DESCRIBE HOW I	NJURY OC	CURED	
OR ATTENDING I DIRECTOR: After hours after death item 28 Is man		3 Suicide 8 Could not be 4 Homicide determined 28a. PLACE OF INJURY — At he building, etc. (Specify)	ome, farm,	atreet, factor	y, offica		28f. LOCATION (Street a City or Town, State)	and Number	or Rural Route Number,	
4 4 2 m	COMPLETE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, d								
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: II	BE	296. SIGNATURE AND TITLE OF SERVIPIER ULL				O.C.M	Allera S		E SIGNED (Month, Day, Year) EC 12,1994	
/	10	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITE	, , , ,			_			ryland 21201	
5		31. DATE THE COIN DEX 1994 July Davidior hards	4							

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FOR STATE REGISTRAR

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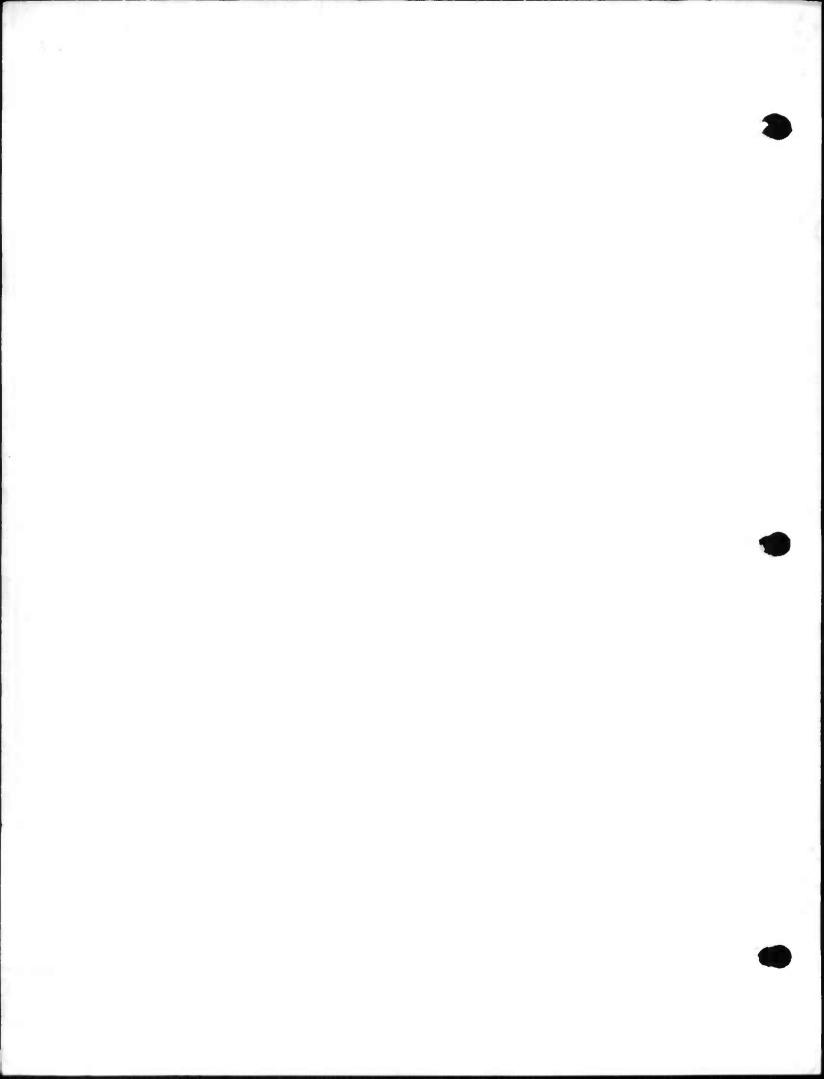
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	E MOCDITAL OD ATTENDIAG DEVOCIDAN. The law requires that the death partitions he executed within
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1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH BEEMAN MONTH 2 141 0140 5. SEX 7. DATE OF BIRTN (Morth, Day, Year) 6. AGE (In vrs. last hirthday IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign 1 XM 2 | F 3 DAYS MONTHS HOURS MARYLAND use as the burial-transit permit, Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR BALTI MORE 10a. STATE 10h. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 2 BALTIMORE 1 X YES 2 NO FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2945 FAIT AVENUE 21224 USA death, Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for use as the burial-tran 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY Specify: WHITE 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. OECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ast of working Elementary/Secondary (0-12) College (1-4 or 5+) GOETZ'S ONCE. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Melden Sumame) at JOHN ACKERMAN MATILDA KRRSS BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 & MRS. 744 CHARLES RYAN S. CURLEY STREET BALTO. MD. e Q 20e, METHOD OF DISPOSITION
1 A Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must 4 Donation 5 Other (Specify) CARY, CEMANN NOTHE COLEMETERY 2-1\$BALTO. CITY MD. 21 SIGNATURE OF FUNERAL SERVICE LICENSEE medical examiner 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME led in by the ft. 2525 FLEET ST. BALTO. MB. filled in by th 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximata ahock, or heart fellure. List only on cause on each line. interval Betwe **IMMEDIATE CAUSE (Final Onset and Death** the attending physician and completely fille mal Hyglene prior to burial, cremation, disease or condition - stage year resulting in death) event, OUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury y the attending phyinjury, or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART ii. Other aignificant conditions contributing to deeth but not recuiting in the underlying ceuse given in Part i. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS certificate has been signed by the State Dept. of Health and AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? Wednovale PERFORMED? Lon Item 23 shows any 1 TYES 2 T NO 1 TES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 0 27. MANNER OF OEATN 28e. DATE OF INJURY (Month, Day, Year) 28h TIME OF 28c. INJURY AT WORK? 28d. OESCRIBE NOW INJURY OCCUREO is marked, DIRECTOR: After this of hours after death with Natural 5 Pending 1 YES 2 NO BY Investigation 2 Accident 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 28 4 Homicide Hem 29a. CERTIFIER CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. THE HOSPITAL OF THE FUNERAL D MPORTANT: 11 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. ALCENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) wed. BE Speciales; Davarre ly 40356 2 2 3 9 94 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH WEM 27) (Type, Print) NAVARRO Bolto MD 100 N. 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Studior Revell 5 1994 DHMH-18 Rev 1/89

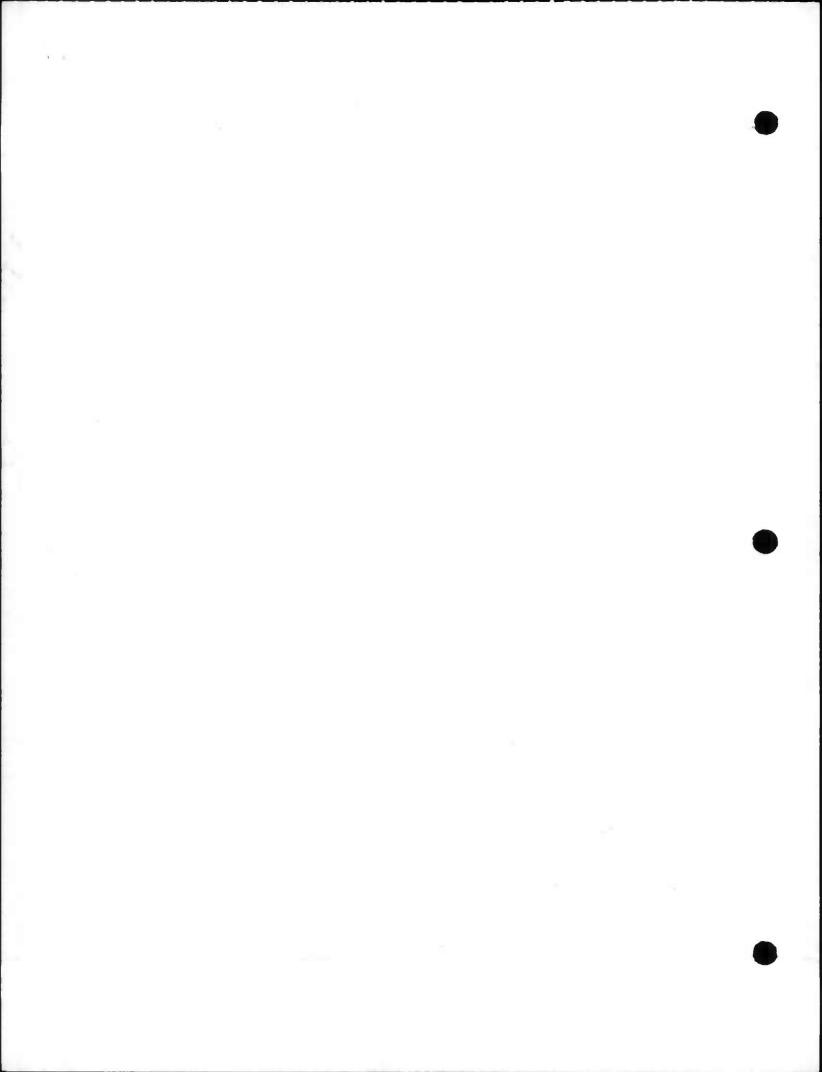
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed writhin 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.
IMPUKIANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
TO BE COMPLETED BY FUNERAL DIRECTOR	1. DECEDENT'S NAME (First, Middle, Last) AUDREY	L	ALTHOFF			2. DATE OF DEATH DECEMBER DAY 8,1994 5:07 P			м	
	4. SOCIAL SECURITY NUMBER 219-92-2433	¹□M²XX 31	8. AGE (In yrs. last birthday) If UNDER 1 YEAR IF UNDER 24 3 1 YRS. MONTHS DAYS HOURS			7. DATE OF BIRTH (Month, Dey, Year) 11/5/1963 Balto				
	9a. FACILITY NAME (# not institution, give st THE JOHNS HOPK RESIDENCE OF DECEDENT				PRE CITY	EATH	9c. COU	INTY OF DI	EATH	
	10a. STATE 10b. COUNTY	ity	111 111 111	10c. CITY, TOWN OR LOCATION Baltimore			16d. INSIDE CITY LIMITS? XIXI VIÈS 2 □ NO			
	100. STREET AND NUMBER 321 West 28		101. ZIP CODE 21211			10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	ARMED	IS. WAS DECENDENT OF HISPANIC ORIGIN? (Sp If yes, specify Cuben, Maxican, Puerto Ricen, 1 YES 2 NO Specify:						
	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	(Give kind of work do life. Do NOT use retired	ECEDENT'S USUAL OCCUPATION Aive kind of work done during most of working a. Do NOT use retired.)			166, KIND OF BUSINESS/INDUSTRY				
	17. FATHER'S NAME (First, Middle, Lest)	ey	usewife							
	19s. INFORMANT'S NAME (Type/Print) Mary Denbow					MILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3038 Keswick Rd. Balto, MD 21211				
	20a. METHOD OF DISPOSITION 1 Burlel VD Gremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other piece) Metre-Crematory 1 2/12 Catonsville, Md									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Rd. Balto, Md 2121									
	IMMEDIATE CAUSE (Final	List only one ceuse on each i	line.		de of dying, suc	h as cerdiac or	reepiratory ar	rest,	Approximate interval Betwee Onset and Deat	th
	disease or condition resulting in death) e. Carabra adema OUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF): Due TO (OR AS A CONSEQUENCE OF):							2		
ATION	Sequentielly list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Prewmacdcon Sepsilo DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d.							Sday	2	
CERTIFICATION										
AL.	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PRIDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF CRUSHER AUTOPSY PROPRIED OF CAUSE OF CRUSHER AUTOPSY PROPRIED OF CAUSE OF CRUSHER AUTOPSY PROPRIED OF CRUSHER AUTOPSY P							s		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
YSICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO									
ВУ РНУ	27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	INJURY WORK?			NOW INJURY OC	W INJURY OCCUREO		
	3 Suicide 6 Could not ba 4 Nomicide detarmined				26f. LOCATION (Street and Number or Rural Route Number, City or Yown, State)					
COMPLETED	29s. CERTIFIER (Check only one) 1 DESTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
TO BE	296. SIGNATURE AND TILE OF ERTHER Medicine Intern 296. LICENSE NUMBER 29d. DATE SIGNED (Month, Dev. Year) Medicine Intern Medicine Intern 296. LICENSE NUMBER 12/8/94									
	31. DATE FILED (Month, Day, Year)									
	DEC1 5 1994	32 REGISTRAR'S SIGNATURE	t .							



BAL	after death
	Nours
DIVISION OF VITAL RECORDS, P.O. BOX 68760	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

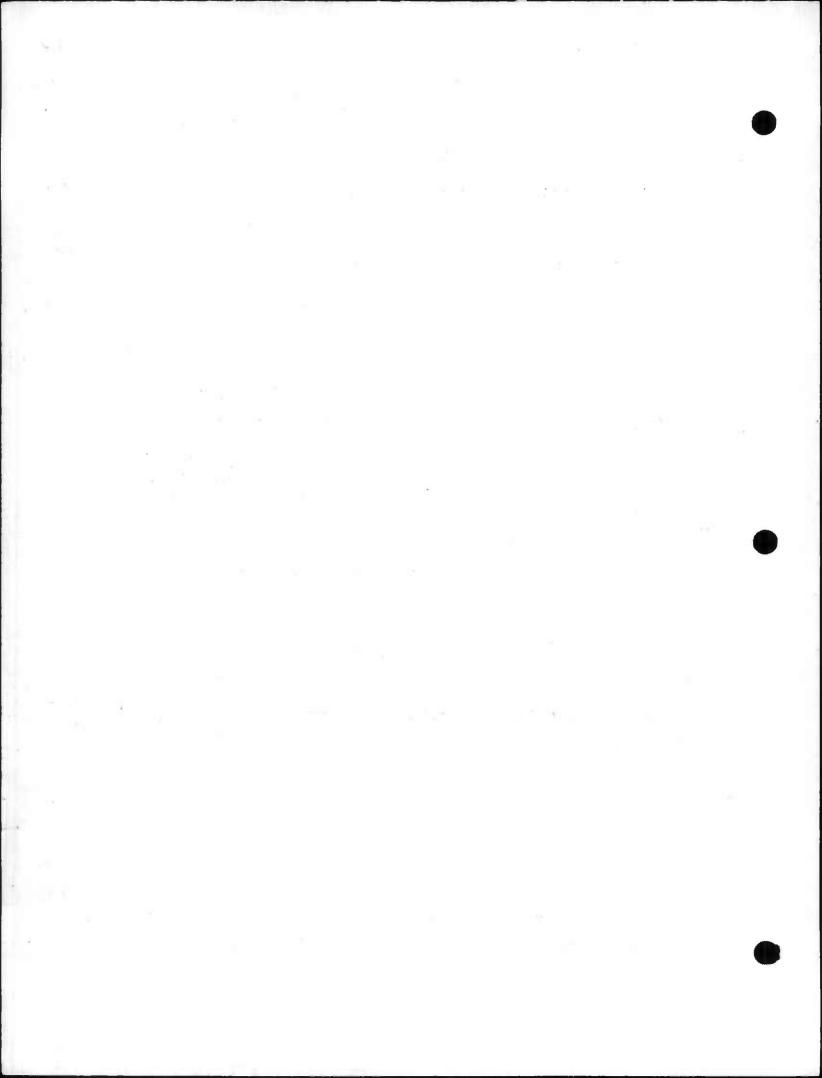
		1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
		1. DECEDENT'S NAME (First, Middle, Lest) GARRETT	O'Neil		LLMIRE JR	T	2. DATE OF DEATH DA		3. TIME OF DEATH 1:35 am M		
pir		4. SOCIAL SECURITY NUMBER 216-20-9822	1 X 2X**2□ F 67	(In yrs. lest birthday) YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 5, 1	Cour	THPLACE (State or Foreign arry) Lto.Md.		
, 2. 3 should	TOR	9a. FACILITY NAME (If not institution, give st Saint Joseph Host RESIDENCE OF DECEDENT				OR LOCATION OF DEA		9c. COUNTY OF	timore		
nit. Pages 1,	DIRECTOR	Maryland Balt	imore	10c. Cl	TY, TOWN OR LOCAL Monkto				10d, INSIDE CITY LIMITS? 1 YES 2 N NO		
020 physician. bunal-transit permit.	NERAL	15032 Manor				21111		USA	WHAT COUNTRY?		
215-0020 attending physician. se as the bunal-trar	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Never Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 X YES IF YES, GIVE WAR OR D	2 NO	If yea, sp	CENDENT OF NISPANIE Pecify Cuben, Mexican, S 2 NO Specify:	C ORIGIN? (Specify Yea , Puarto Rican, atc.)	Bla	CE — American Indian, lock, White, atc.		
2 2 2	PLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementery/Secondary (0-12)	CATION completed) College (1-4 or 5+) 4.	(Give kind of life, Do NOT L	s usual occupation of work done during mouse retired.) —Seafoo	ost of working	Whole:	swess/wdustry sale seafood			
YLAND S by the hospital be detached for at once.	E COMPL	17. FATHER'S NAME (First, Middle, Last) Garre	tt O. Bill	mire	 E (First, Middle, Melden						
	TO BE	190. INFORMANT'S NAME (Type/Print) Mrs. Marjorie		19b. MA/LIN		end Number or Rural Ro	oute Number, City or Town Monkton	n, State, Zip Code)	21111		
e 6 may ector, pa		20a. METHOD OF OISPOSITION 2\(\) Burlel 2 \(\) Cremetton 3 \(\) Remote Remote 4 \(\) Donellon 5 \(\) Other (Specify)	oval Irom State 20b	b. PLACE AND DATE	of disposition (Na other place) Ridge	ama of	OATE 20c. LOC	CATION — City or 1			
SALT death. e funeral. al.		21. SIGNATURE OF FUNERAL SERVICE LID			Mitc.	nd adoress of faci		Home, In	nc.		
tely filled in by mation, or reme t, the medica		IMMEDIATE CAUSE (Final disease or condition	OBESITY HY	ech line.	ILATION SY		as cardiac or reapi	ratory srrast,	Approximate Intervsi Between Onset and Death		
certificate be executional physician and hygiene prior to burn other traumatic	ERTIFICATION	Sequantielly list conditione, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	b. CONGESTIVE DUE TO (OR AS A		FALURE		-		UNKN		
RECORD requires that the been signed by the cof Health and M shows any Inji	MEDICAL C	PART II. Other eignificant conditions	s contributing to death b	put not rasulting	in the undariyin	ig ceuse givan in P	Pert I. 24s. WAS AN PERFOR 1 TYES 2	MED?	Ib. WERE AUTOPSY FINOINGS AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO		
B ste h	YSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	petiant 3 🗆 DOA	OTHER:	LACE OF OEATH (Chec					
O FH sight	ВУ РНУ	27. MANNER OF DÉATÀ 1 Astural 5 Pending 2 Decident Investigation	28a. DATE OF INJURY (Month, Day, Year)		M 1	YES 2 NO	26d. DESCRIBE HOW IN	NJURY OCCURED			
DIVISION OR ATTENDING DIRECTOR: After hours after death Item 28 Is ma		3 Suicide 8 Could not be datermined	28a. PLACE OF INJURY building, atc. (Spec	cify)			261. LOCATION (Street a City or Town, State)		Route Number,		
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TO THE HOSPIT TO THE FUNERA be filed within 7	TO BE	20. NAME AND ADDRESS OF BERSON WAS	J. Pmy }		9	29c. LICENSE NUMI	dEM .	294. DATE SIGNE	D (Month, Dig: Ner)		
		30. NAME AND ADDRESS OF PERSON WHO DR MARK KELEME 31. DATE FILED (Month, Day, Ward)		ROAD TO		D 21204					
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		1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
		1. DECEDENT'S NAME (First, Middle, Last) Mildred	В		us AK	A Ame				2. DATE OF OEATH		994	3. TIME OF OEATH 7:40 A M	
Pin		4. SOCIAL SECURITY NUMBER 218 44 5021	1 □ M 2 🄀 F	AGE (In yrs.	lasi birthday) YRS.	IF UNDER t	YEAR DAYS	IF UNDER HOURS	MIN.	Morth, Day, Year) Aug. 19	_	Mar	yland	
1, 2, 3 should	TOR	96. FACILITY NAME (If not institution, give str Maryland Genera RESIDENCE OF DECEDENT		al	9b. CITY, TOWN OR LOCATION OF DEATH Baltimore							9c. COUNTY OF OEATH		
Pages	DIRECTO	Maryland ===				Y, TOWN OR		IDN					10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
an. transit permit.	FUNERAL	607 Pennsylvania				P		212	201		U	J.S.A		
Z15-0020 attending physician. se as the burial-transit	B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT E FORCES? 1 U IF YES, GIVE WAR	YES 25	ARMED ND	11 1	yes, spe			ORIGIN? (Specify Y Puerto Ricen, atc.)	14. RACE Black Specif	White		
al or attend for use as	COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	-	DECEDENT'S (Give kind of viife. Do NOT us	work done du se retired.)	CUPATIO	ON st of working	ng	16b. KIND OF B		MILOC		
the hospital or detached for u	COMPI	4th 17. FATHER'S NAME (First, Middle, Last)	2 01-		Housew	rife		18, MOTI	HER'S NAME					
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5 5	유	Frederick Bauhau	us		2038 I								and 21122	
e 6 may rector, p		20s. METHOD OF DISPOSITION 1 1 Burist 2 Cremetion 3 Remo 4 Donation 5 Other (Specify)	wai from Stata		cremetory or of State				m. 1		OCATION —	-	wn, State , Maryland	
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urs af in by r rem		23. PART I. Enter the diseases, or co shock, or heart fellure. L iMMEDIATE CAUSE (Finei disease or condition	iet only one cause	on aech II	Ine.		he mo	de of dyl	ing, such a	na cardiac or rea	piratory err	reat,	Approximata interval Batween Onset and Death	
executed with ho and completely filled to burial, cremation, or matic event, the matic event, the matic event the event the event the matic event the matic event the even	,	resulting in death)	Hypox out to (or Chron	RASA CONS	SEQUENCE OF	n: ictiv	re I	Pulm	nonar	y Disea	ase		unknown	
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th certificat ending phy Hyglene p	ERTIFIC	CAUSE (Disease or injury that initiated avants resulting in death) LAST	OUE TO (OF	R AS A CONS	SEOUENCE OF	F):								
that the by the and	EDICAL CE	PART II. Other aignificant conditions	contributing to de	eth but no	t regulting (In the und	erlying	g ceuee (given in Pa	PERFO	N AUTOPSY DRMEO?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?	
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NG PHYSICIA fer this certificate with the marked, or	РНҮ	27. MANNER OF DEATH 1 7 Naturel 5 Pending	26s. DATE OF IN. (Month, Day,	JURY	285. TIM		8c. INJ		2	8d. DESCRIBE HOW	INJURY OC	CURED		
TTENDI TTOR: A after da	ETED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE DF it building, atc	NJURY — At c. (Specify)	home, farm, a	street, factor				81. LOCATION (Stree City or Town, Stat	t and Number	or Rural A	oute Number,	
IAI 23 IAI	COMPLE	29s. CERTIFIER (Check only one) 1	CIAN: To the best of my) and manner as stated.	
TO THE HOSP TO THE FUNEI De filed within	BE	29b. SIGNATURE AND TITLE DF CERTIFIER	OF CERTIFIER 29c. LICENSE NUMBER 89229 29d. DATE SIGNED (Mornth, Day, Year) $12-12-94$							(Month, Day, Year) 12-94				
	10		inakaran, M.D. c/o Maryland General Hospital											
7		31. DATE FILED (Month, Day, Year)	33. HERSTRAB'S	S SIGNATURE		rialy	ı ıd.	iiu (———	at nos	PILAI			
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the float the relatined by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

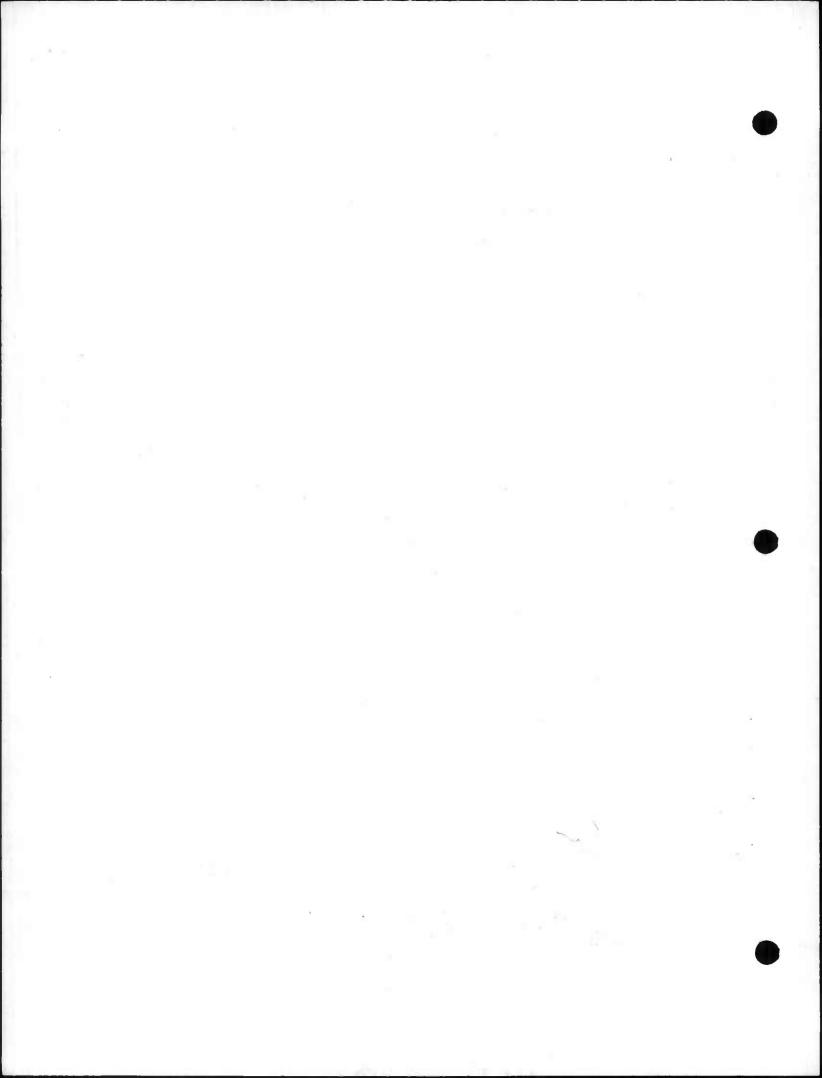
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	1 - FOR STATE REGISTRAR	STATE OF MAR	YLAND /	DEPARTMEN ERTIFICAT	T OF HEALTH AND		GIENE i. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) LEE B, COH	ENS				2. DATE OF DEA	TH DAY	YEAR	3. TIME OF DEAT	Н	
	4. SOCIAL SECURITY NUMBER 218-5288	5. SEX 8. A	GE (In yrs tes	YRS. SF UND	R 1 YEAR IF UNDER 24 HRS DAYS HOURS MIN.		H /		LACE (State or Fo		
OR	90. FACILITY NAME (If not institution, give so	treet end number)		9b. CIT	y, TOWN OR LOCATION OF	DEATH	9c. COUN	TY OF DE	ATH		
DIRECTOR	100. STATE 10b. COUNTY	1		10c. CITY, TOWN	OR LOCATION				10d. INSIDE CITY LIMITS? 1V YES 2		
FUNERAL	3809 Penha	ust Aug	,		10f. ZIP CODE 212	15	10g, CIFIZ	EN OF WI	HAT COUNTRY?	NO	
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O	ES 2 K	IMED 13	. WAS DECENOENT OF HISP If yee, specify Obben, Mex 1 YES 2 NO Spe	PANIC ORIGIN? (Spec Ican, Puerto Rican, e ocity:	Ify Yee or No—	14. RACE Black, Specify	- American India White, etc. Black	in,	
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COMPLETED	17. FATHER'S NAME (First, Middle, Last)		5	elf-em	ployed 18. MOTHER'S	NAME (First, Middle, A		re	anne		
TO BE	Hoert Cohens 16. Necomant's Name (Type/Print) Tohnson 18b. Mailing adores (Syred end Number or April Poure Number, City or Sown, State Zip Code) Rev. Hona Johnson 3809 Penhurst ave Belt md 2/215										
	200; METHOD OF DISPOSITION 200; METHOD OF DISPOSITION 3 Removal from State 200; METHOD OF DISPOSITION 3 Removal from State 200; METHOD OF DISPOSITION 3 DAYE 200; UCCATION — City or Town, State 200; METHOD OF DISPOSITION 3 DAYE 200; UCCATION — City or Town, State 200; METHOD OF DISPOSITION 3 DAYE 200; UCCATION — City or Town, State 200; METHOD OF DISPOSITION 3 DAYE 200; UCCATION — City or Town, State 200; METHOD OF DISPOSITION 3 DAYE 200; UCCATION — City or Town, State 200; METHOD OF DISPOSITION 3 DAYE 3 DAYE 4 DONE DAYE 4 DONE DAYE 4 DONE DAYE 4 DONE DAYE 5										
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENGEE JAN	MOST	n Jr 122	MAME AND ADDRESS OF March F	H-Wes	F Any				
	23. PART I. Inter the diseases, or on those, or heart fellure. IMMEDIATE QAUSE (Finel disease or condition recuiting in death)	List only one ceuse of the stat	n eech line).		uch ss cerdiec or	reepiratory srre	st,	Approxims Interval Be Onset and	tween	
CERTIFICATION	CAUSE (Diseese of injury	DUE TO (OR A									
CERIT	thet initieted events resulting in desth) LAST	DUE TO (OR A	AS A CONSEC	DUENCE OF):							
PHYSICIAN: MEDICAL	PART II. Other significent condition	e contributing to deet	h but not r	resulting in the u	nderlying ceuse given	PI	AS AN AUTOPSY ERFORMED?		WERE AUTOPSY FINANAILABLE PRIOR 1 COMPLETION OF COMPLETION	го	
AN:	DID TOBACCO USE CONTR	RIBUTE TO CAUSE				NIN 🗆			1 TES 2 N	0	
	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		DOA 4 Nu		e 6 🗆 Other (Specifi	y)				
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COMPLETED	3 Suicide 8 Could not be determined	28e. PLACE OF INJi building, etc. (5	Specify)			City or Town,	- <u>-</u>		ute Number,		
JMPL					time, date end place, end di opinion, death occured at ti				end menner se st	eted.	
滿	290 MIGHATURE AND TITLE OF CERTIFIER				29c. LICENSE N		29d. DATE		Month, Day, Year)	T.C.	
2	20, NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF	DEATH OTES	W 170 / Kenn Drint	HITCHUR	COI WAIN	1/	11	11		

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		1	FOR STATE REGISTRAR	STATE OF MARY					EALTH AND	MENTA	AL HYGIEN	E		
		į.	1. DECEDENT'S NAME (First, Middle, Last)							2. DATE	E OF DEATH	v	YEAR 3.	TIME OF DEATH
			.Jam	es			Cam	obe:	11	Dec	ember			:11 A M
-			4. SOCIAL SECURITY NUMBER 212-28-9461	1 M 2 □ F	6	nst birthday) 1 YRS.	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mon	E OF BIRTH (th, Day, Year)	_	Country)	vland
2, 3 should	OR O		9a. FACELITY NAME (If not institution, give st Maryland Gener	al Hospit	al				timore				Y OF DEAT	
-	[5	F	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	v		T son our	Y, TOWN C	20.10047	1011					
permit, Pages	DIRECTOR	- 10-	Maryland			100. (1)		lti	more	1				d. INSIDE CITY LIMITS? YES 2 NO
JS.	FUNERAL		2215 Huntingdo	n Avenue			101. ZIP CODE 21211					10g. CITIZEN OF WHAT COUNTRY?		
21215-0020 al or attending physician, for use as the burial-transit	BY FUR		11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR	8 2X			If yes, spe	ENDENT OF HISPAI ecity Cuban, Maxice 2 NO Specif	n, Puerto		or No— 1	4. RACE — Black, W Specify:	American Indian, thita, atc. white
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BALTIMORE, ter death. Page 6 may be the funeral director, page wal.	must be	- 11	20e. METHOD OF DISPOSITION 1 Burial			rematory or or			e Co.	12/		CATION — CI		stata yland
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hours of in t	medical		23. PART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Final	complications that cause List only one cause on	ed the d each lin	leeth. Dor na.	not enter	the mod	de of dying, auc	h aa ca	rdiec or reapl	ratory arre	mt,	Approximate Interval Between Onset and Dasth
rety	traumatic event, the		disesse or condition resulting in death)	Sept:	ic S	shock	C							24hrs
68760, executed within and completely burial, cremati	even			Intest				rat	ion					
secu and o bur	on age		Sequentielly list conditions, if any, leading to immediate	b. DUE TO (OR AS				Lac.	1011					
BO)	CAT		cause. Enter UNDERLYING CAUSE (Disease or injury	myoca			infarction							
t, P.O. BOX leath certificate be a attending physician rital Hygiene prior to	ry, or other traumatic		that initiated events reaulting in death) LAST	DUE TO (OR AS	A CONS	EOUENCE O	F):							
OS, P he death the atten Mental H	르		PART II. Other significant condition	s contributing to deeth	but not	resulting	in the un	derlying	cause given in	Part I.	24a. WAS AN	AUTOPSY	24b. WE	ERE AUTOPSY FINDINGS
RECORDS, I	shows any is : MEDICA		hypertens								PERFOR		CC	AILABLE PRIOR TO DMPLETION OF CAUSE DEATH?
PER S	show V: M		DID TOBACCO USE	CONTRIBUTE TO	CAI	USE OF	F DFA	TH Y	res I No				1 (YES 2 NO
VITAL AN: The law Hitcate has b	ed, or Item 23 s PHYSICIAN:		25. WAS CASE REFERRED TO MEDICAL EXAMINER?		<i>-</i>	00L 01		26. PL	ACE OF DEATH (Ch		one)		1	
N N N	VSI	ı	1 YES 2 NO	HOSPITAL: 1 X Inpatient 2 ER/Ou	rtpatient	3 🗆 DOA	OTHER 4 Num		e 5 🗆 Residence	8 🗆 Oth	er (Specify)			
NOF VI	Arked.		27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28a. DATE OF INJURY (Month, Day, Year)		28b. TIM	E OF JURY M		URY AT RK? 'ES 2 NO	28d. DE	ESCRIBE HOW II	NJURY OCCL	IRED	
ONISION OF HERTON A	28 18 11		2 Accident Investigation 3 Suicide 6 Could not be datermined	28a. PLACE OF INJUF building, etc. (Sp	RY — At I	nome, farm, s	street, fact	ory, office			CATION (Street a y or Town, State)	nd Number o	r Aural Rout	e Number,
2 2 2	COMPLE			ICIAN: To the best of my kno										nd manner ee stated.
TO THE HOSPITAL TO THE FUNERAL Se filed within 72	BE BE		296. SIGNATURE AND TITLE OF CERTIFIER D. Santo	110	3	>			HOUSE NUI	WBER 8	91,91			onth, Day, Year)
E E E	≝ p	I	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF D	-									74.
12		-	Ronny Santos	a, M.D. C.	/O I	uary.	Land	Ge	neral l	iosp	rtal			
			on DEC 1 5 1994 Ju	UA QUINDEDE PAR	COLON									



FOR

		1 - FOR STATE REGISTRAR	OF MARYLAN			F HEALTH AND OF DEATH	MENTAL HYGIEN REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last) GEOT	ge Ernes	st Dimic	ck, Jr.		2. DATE OF DEATH DO DECEMBER		3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER 5. SEX		yrs. last birthday)	IF UNDER 1 YE		7. DATE OF BIRTH (Month, Day, Year)		NPLACE (State or Foreign
P		214-26-6274 1½ M 2		YRS.			12/13/19	28 Es	sex, MD
3 should	Œ	9e. FACILITY NAME (If not institution, give street and number 1997)	oer)		9b. CITY, TO	WN OR LOCATION OF D	DEATH	9c. COUNTY OF	
.2	CTOR	853 Loalan Road				Dundalk		Balti	more
Pages	DIRE	100. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR L				10d. INSIDE CITY LIMITS?
регтій.	RAL D	Maryland Balti 100. STREET AND NUMBER	more			10f. ZEP CODE	<u>ndalk</u>	10g. CITIZEN OF	1 YES 2 NO
- <u>SE</u>	ER/	853 Loalan Avenue				21	222		d States
020 physician. burfal-transit	FUNE	11. MARITAL STATUS 1 Never Merried 2 Merried FORCES	CEDENT EVER IN U 37 1 V YES GIVE WAR OR DATE	S. ARMED			NIC ORIGIN? (Specify Yes	s or No- 14. RAC	CE - American Indian, ck, White, atc.
9 2 9	B	3 Widowed 4 Divorced	GIVE WAR OR DATE	S		YES 2 NO Spec		Spe	
	9	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	10	6a. DECEDENT'S		PATION g most of working	16b. KIND OF BUS	SINESS/INDUSTRY	MILCO
21 for 1	틸	Elementary/Secondary (0-12) College (1-	4 or 5 +)	IIIe. Do NOT u	se retired.)				
AND the hospit detached	COMPLET	11 Years 17. FATHER'S NAME (First, Middle, Last)		TeLeph	none Re		AME (First, Middle, Maiden	nication	S
1 2 2 E	ы	George E. Dimick, Sr.					ine Wuhlsc	,	
retained 5 should	0 8	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Str	reet and Number or Rural	Route Number, City or Tow	m, State, Zip Code)	
y be		Mrs. Doris M. Dimick		853	Calan I	Avenue Du	ındalk, Mar	yland 2	
0 0 5 3		1 M Buriel 2 ☐ Cremetton 3 ☐ Removat from St 4 ☐ Donetton 5 ☐ Other (Specify)	ate 20b. Pt	EACE AND DATE	of bispositio ther plece)	N(Name of	DATE 20c. LO	CATION — CITY OF T Dundalk	
ALTIM death. Page funeral direc		21. SIGNATURE OF FUNERAL SERVICE LICENSEE		crea ii	22. NAM	E AND ADDRESS OF F	ACILITY		
BALTIN or death. Pag the funeral di val.		> Cohnney L. L	libles				meral Home ve. Dundal		
in by remo		23. PART i. Enter/the diseases, or complication shock, or heart failure. List only or	ne ceuse Dn eecl	h line.	not enter the	mode of dying, su	ch as cardiac or respi	ratory arrest,	Approximate interval Between
in the second		immediate cause (Final disease or condition recuiting in death)	retash	hot.	anou	shi C	۲.		9 mas.
s/60, nted within completely sal, cremat		_ "	UE TO (OR AS A CO	ONSEQUENCE O	F):	4.			
x 687 executed in and con to burial,	LION	Sequentially list annelitions	UE TO (OR AS A CO						
cate by hysicia	CA	cause. Enter UNDERLYING CAUSE (Disease or injury							
death certificate attending physical ential Hygiene pri	ERTIFICAT	thet initiated evente resulting in desth) LAST	UE TO (OR AS A CO	ONSEGUENCE O	F):				
the death y the attent of Mental H	0	d							
that the that the that the that the that the that the the the the the the the the the th	일	PART II. Other eignificant conditions contribut	ing to death but	nDt resulting	in the under	lying ceuee given in	Pert i. 24a. WAS AN PERFOR	RMED?	b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
requires the seen signed of Health a	MEC								OF DEATH?
law law	AN	DID TOBACCO USE CONTRIBUTE TO					N 🗆		
上 电 电		EXAMINER? HOSPITA		PLACE OF DEA	OTHER:	Nome 5 Residence	6 Other (Specify)		
INSICIA is certification in the	F	27. MANNER OF DEATN 280. D.	ATE OF INJURY Jonth, Day, Year)	28b. TIW		INJURY AT WORK?	28d. DESCRIBE NOW I	NJURY OCCURED	
DING PHYS After this death with	BY	1 Natural 5 Pending 2 Accident Investigation			M 1	YES 2 NO			
TTENDI STOR: A after de	ΕĐ	3 Suicide 6 Could not be 4 Nomicide determined	ACE OF INJURY — illding, atc. (Specify)	At home, term,	street, factory,	office	26t. LOCATION (Street a City or Town, State)	and Number or Rural	Route Number,
Po Billion	APLE	29e. CERTIFIER (Check only one)							
HOSPITAL FUNERAL Within 72	8	2 MEDICAL EXAMINER: On the bad	is ot exemination e	nd/or Investigation	on, in my opinie	on, death occured at the	e time, date end place, en	d due to the ceuse	(e) end manner es atated,
품 품 물	띪	296. SIGNATURE AND TITLE OF CERTIFIER	2 /			29c. LICENSE NU	MBER CY	29d. DATE SIGNE	D (Month, Day, Year)
6633	2	30. NAME AND ADDRESS OF PERSON WHO COMPLETE	D CAULE OF DEATH	N (ITEM 27) (Type	Print)	104	01810.	14	12/74.
121		Nimala Jaraf	10,1	V. S.	scor.	St	Balto	more	
8		31. DATE FILED (Month, Day, Year) 32. RE 15 1994	GISTRAR SHANAT	Munder	hardall				
		12-12 13 1337	0						

been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit, or Health and Mental Hygiene prior to burial, cremation, or removal. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 nours after death. requires that the death certificate be executed within

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TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECTO be filed within 72 hours at IMPORTANT: If Item 28

60 DIRECTOR: #

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DIVISION OF VITAL RECORDS, P.O. BOX 68760 DR ATTENDING PHYSICIAN: The law

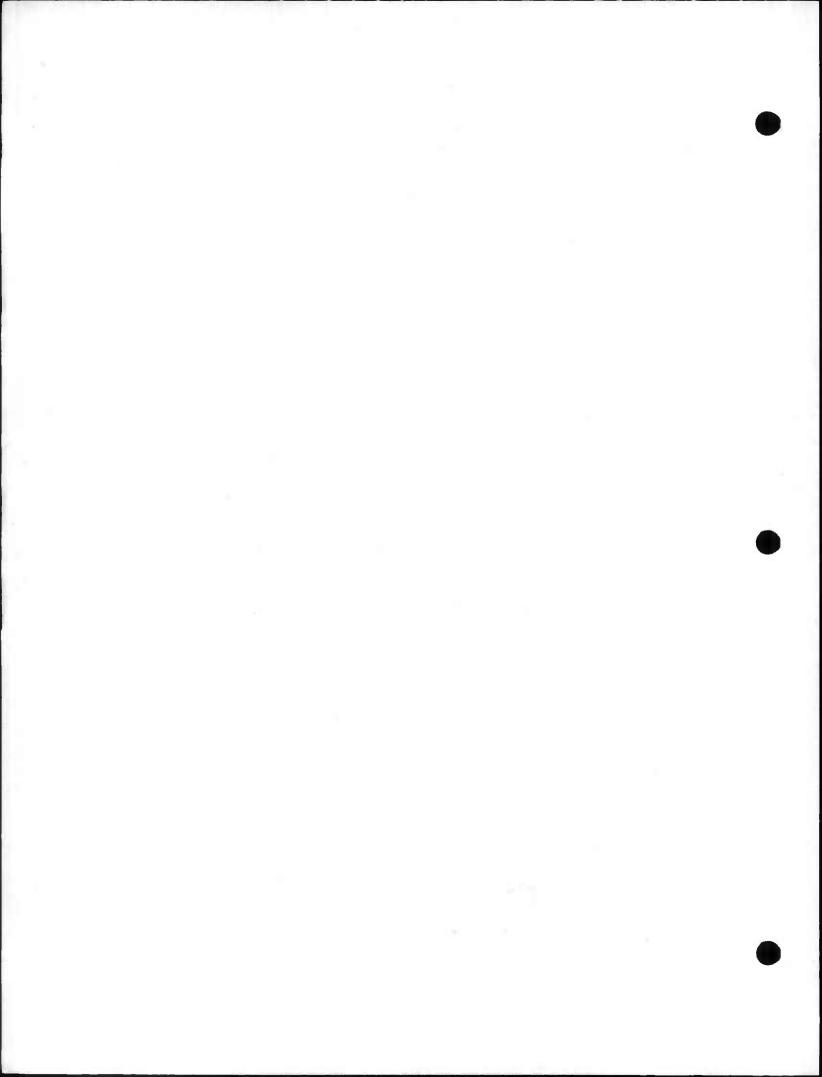
FOR STATE REGISTRAR 10a. STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATN Rexford H. Feaster 1994 December 13, 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 24 HRS. 7. DATE OF BIRTN (Month, Day, Year IF UNDER 1 YEAR 8. BIRTNPLACE (State or Foreign DAYS HOURS MIN. 1 X M 2 7 F 71 577 28 8844 YRS. Feb. 14,1923 D.C. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Meridian Nursing Home Hammonds Lane Baltimore Anne Arundel RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Anne Arundel Pasadena 1 - YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 461 Edgewater Road 21122 U.S.A. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
 if yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, While, atc. 1 Never Married 2 Married FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES 2 NO If yes, specify Cuban, Maxican, Puerto Ri
1 YES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced World War II White 16a. DECEDENT'S USUAL OCCUPATION

(Chan kind all work done during most of working COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) Vice President Salisbury Steel 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Meider Symame) Gale Feaster Edith Cooke BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Floute Number, City or Town, State, Zip Code) 2 Nancy Bassler 461 Edgewater Road Pasadena, Maryland 21122 20a. METNOD OF DISPOSITION

1 X Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata OATE ry, cremetory or other place)
State Veterans Cem. ☐ Donation 6 ☐ Other (Specify) Md. 12/15 Hurlock, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225 23. PARTI. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betwe Onset and Death IMMEDIATE CAUSE (Finel disease or condition ens 12 resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, If any, leading to immediate cause. Enter UNDERLYING 1+ CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 110 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO M 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL 1 YES 2 NO ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 4 Mursing Home 5 Residence 6 Other (Specify) 28a. OATE OF INJURY (Month, Day, Year) 27. MANNER OF OFATH 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO B 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide ETED | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Nomicide 29s. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. COMPL he basis of axamination and/or investigation, in my opinion, death occured at the time, data and placa, and dua to the cause(a) and manner as stated. TITLE OF CERTIFIE 29b. SIGNATURE AN 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 2 30. MAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print) Juli 32 testor hardali DEC 15 1994



P.O. BOX 68760. DIVISION OF VITAL RECORDS,

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CERTIFICATION

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BALTIMORE, MARYLAND 21215-0020

94 37224 Item # 1 Film # G 718 12-15-94 N.A. Per funeral home STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR **CERTIFICATE OF DEATH** REG. NO 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF OEATH VEAR Florence A FRIEDMAN 4:30 AM W 12 LO 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (Stetn or Formion DAYS HOURS 218-18-4894 1 M 2 XF 71 YRS. AUG.12,1923 MD 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORE UNIVERSITY HOSPITAL RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY BALTIMORE MD BALTIMORE 1 YES 2 XNO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21209 USA 6502 GREENSPRING AVE 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- RACE — American Indian, Black, White, etc. 1 Never Married 2 Married If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 TYES 2 TONO 3 Widowed 4 Divorced Specify: Specify: WHITE 15. OECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 166. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) CLOTHING SALESPERSON 12 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle Meiden Surname COHEN LENA NEEDLE **JACOB** 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7 VALLEY GLEN COURT, REISTERSTOWN, MD 21136 19s. INFORMANT'S NAME (Type/Print) DR. DEBORAH WEBER 20a. METHOD OF DISPOSITION
1 V Burlel 2 Cremetion 3 Removal from Stata
4 Donetion 8 Other (Specify) 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION /Name of DATE 12-11-94 BALTIMORE, MD CHIZUK AMUNO-ARLINGTON 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory arrest, Approximete shock, or heart feilure. Liet pnly one cause on each line Interval Between Onset and Death IMMEDIATE CAUSE (Fine) disease or condition NON SMALL CELL LUNG Cancer 1991 resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentisity list conditions. **OUE TO (OR AS A CONSEQUENCE OF):** if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditione contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS Diabetes Mellitus AMILABLE PRIOR TO COMPLETION DE CAUSE 1 TYES 2 NO DE DEATH? t TYES 2 THO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🗆 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER 1 YES 2 NO Impatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF CEATH 28e, DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DEȘCRIBE HOW INJURY OCCURED 18 Natural 5 Pending 1 YES 2 ND Investigation 2 Accident 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State)

3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, offica building, etc. (Specify) 8 Could not be determined 4 Homicide

29e. CERTIFIER (Check only one)

29 MENICAL EXAMINED: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner ea stated.

2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data end place, and due to the ceuse(s) end menner es stated. 290. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

Lund8741N ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) rfundstein

225. Greene Street BAHMONE 91901

D45114

31. DATE FILED (Month, Day, Year)

JOANN

32 EGISTRAR'S SIGNATUR

12/10/94

NEEDLE

JACOB

DR. DEBORAH WEBER

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CHIZUK AMUNO-ARLINGTON 12-11-94 I

7 VALLEY GLEN COL

SOL LEVINSON & BROS. 6010 REISTERSTOWN RC

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attending physician. use as the burial-transit permit, Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

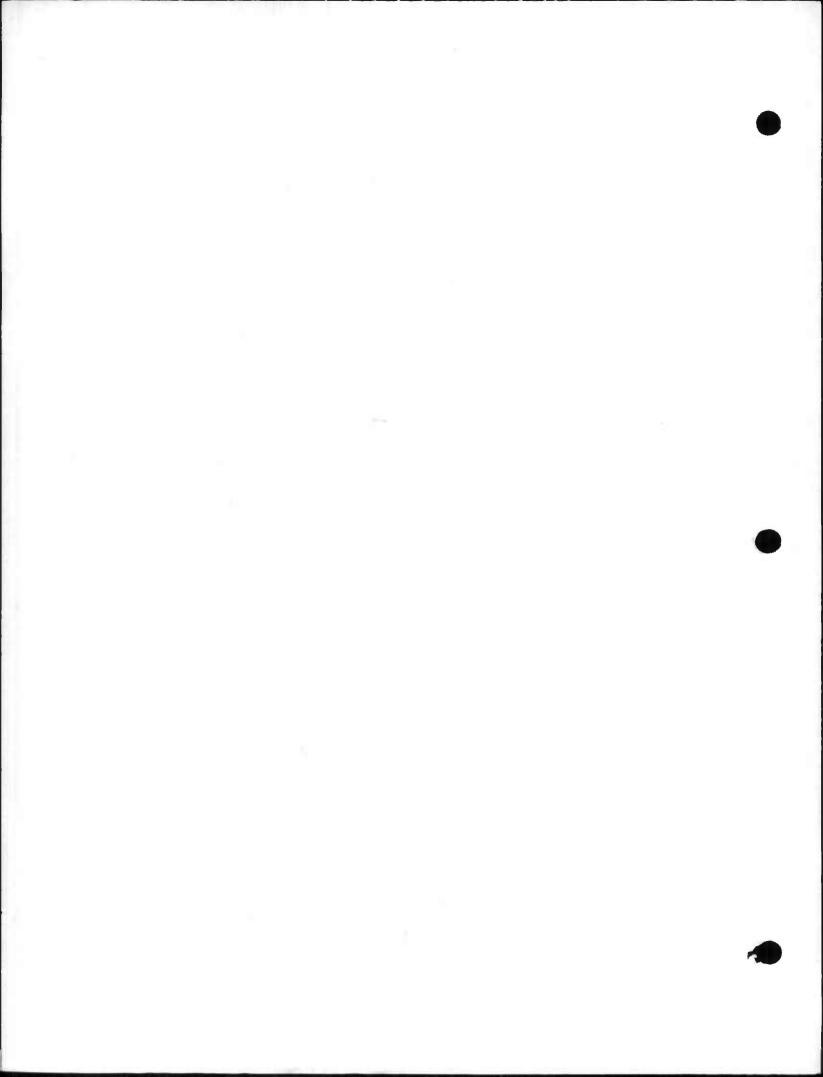
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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-	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Amounts after death. Page 6 may be retained by the hospital or	2	9	Σ

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-	1 - FOR STATE REGISTRAR	STATE OF N	ARYLAND C	DEPAR	TMEN ICAT	T OF H E OF	EALTH DEAT	AND I	MENTAL	HYGIEN REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)			<i>a</i> . !					2. DATE OF MONTH	DA		YEAR	. TIME OF OEATN
	4. SOCIAL SECURITY NUMBER	Jean El	6. AGE (In yrs. la			R 1 YEAR	IF UNDER	24 HRS.	Decen		13, 1		ACE (State or Foreign
	235 56 3503	1 🗌 M 2 🔀 F	58	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, I	Day: Year)	1936	Country) Mary	
	9a. FACILITY NAME (If not institution, give a	treet and number)			96. CIT	r, TOWN O	R LOCATIO	ON OF DE				NTY OF DEA	
O. I	4304 Third St	reet			Ba:	Ltimo	ore				Ann	ne Aru	undel
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN	OR LOCATI	ION					1	0d. INSIDE CITY
E I	Maryland Ann	ne Arunde	:1	Ba	altir	nore							LIMITS?
FUNERAL	10e. STREET AND NUMBER					101.	ZIP CODE	E			10g. CITI	IZEN OF WH	AT COUNTRY?
l Ä	4304 Third Str						212					J.S.A.	
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEOEN FORCES? 1 IF YES, GIVE W	YES 2 X	RMED NO			cify Cuba		IIC ORIGIN? n, Puerto Ric		or No-	14. RACE Black, 1 Specify:	- American Indian, Whita, atc. White
	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. Di	ECEOENT'S	USUAL O	CCUPATIO	N of workin	og .	16b, K	IND OF BU	SINESS/IND	DUSTRY	7711100
삘	Elementary/Secondary (0-12)	College (1-4 or 5 a	·) ///	Do NOT u	se retired.)				I.,	r1 3		T	**
N N	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refined.) ASSISTANT ACTIVITY DIR. Meridian Nursing Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname)								ng Home				
0 B	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
-	Diana Hoover			1304	T	hird	Str	eet	Ва	ltimo	re, l	Maryla	and 21225
	20a. METHOO OF DISPOSITION 1	oval from State ntombment	20b.PLACE cametery, cn		ther plecel				12/16			city or Town	i, State Maryland
	21. SIGNATURE OF FUNERAL SERVICE LI	ENSEE		6.	22. G	eorge	e J.	Gon	ce Fu	neral	Home	e P.A	•
\vdash	23. PART I. Enter the diseases or	omplications the	t ceused the d	eeth. Do i	not enter	the mod	KITC de of dyl	nle ng, auci	HWY .	Balt c or respi	ratory arr	e, Md	. 21225
	ahock, or heert fallura- iMMEDIATE CAUSE (Final disease or condition	Cist only one cau	ese on each line	e. (T)	100	110							Onset and Death
	resulting in deeth)	DUE TO	(OR AS A CONSE	OUENCE O	VT S	140) (wi	loer	-) Yr 5-
Z	Secure Maller Heat constitutions	b											
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO	(OR AS A CONSE	OUENCE O	F):								
E	CAUSE (Disease or Injury that Initiated eventa resulting in deeth) LAST	DUE TO	(OR AS A CONSE	OUENCE O	F):								
CER	resulting in deetily Exst	d	(-1)-										-
	PART II. Other algnificent condition	ne contributing to	death but not	resuiting	in the u	nderlying	cauae ç	given in	Part I. 2	4a. WAS AN PERFOR			VERE AUTOPSY FINDINGS
EDICAL									_ '	YES 2	. /	C	OMPLETION OF CAUSE F OEATH?
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AN	25. WAS CASE REFERRED TO MEDICAL	CONTRIBUT	E IO CAU	JSE 0	r DEA] NO	ack only one)				
SIC	EXAMINER?	HOSPITAL:	ER/Outpetlant	3 DOA	OTHE		V		6 Other (Specify)			
PHYSICIAN:	27. MANNER OF DEATH	28s. DATE OF (Month, D	INJURY my, Year)	26b. TIM		28c. INJU	JRY AT			RIBE HOW I	NJURY OC	CUREO	
B	1 Pending 2 Accident Investigation				М		ES 2	NO					
TED	3 Suicide 6 Could not be 4 Nomicide determined	building,	F INJURY — At he atc. (Specify)	ome, farm,	street, fac	tory, offica			28f. LOCAT City or	ION (Street a Town, State)	and Number	or Rural Rou	ite Number,
MPLET		ICIAN: To the best of											nd manner as stated.
00	396 SIGNATURE AND TITLE OF CERTIFIE		1	- Jungari	,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		NSE NUN		- preve, att		E SIGNED (A	
ro BE	OR HAME AND ADDRESS OF PERSON WAS	2020 J		·			300 BIOL	0	315	_)	>	12/	14/94

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type) 600

Cra 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURED DANGEL DEC 15 1994



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	Date & Committee and the state of the state
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SION OF VITAL	CONTINUE DEPOSITIONS The New or

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The two mounts that the death certificate be executed within the found the funeral director, page 5 may be retained by the hospital or attending physician.

TO THE FUNERAL CHRISTON After this certificate has been uponed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be had within 72 hours after ones with the Sam Dept. of that has a shown any injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Day, Year)
DEC1 5 1994

22 RECUSTRANTS SIGNATURE

		1 - STATE REGISTRAR				CE	RTIF	ICATE (MICH	TAL HYGIEN			
		1. DECEDENT'S NAME (First, Midd	dle, Last)	Jera	MQ	6	0/0	bn s	SON			ATE OF OEATH		94	3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (A	n yrs. last	birthday)	IF UNDER 1 YE	-	DER 24 HRS.		ATE OF BIRTH forth, Day, Year)			HPLACE (State or Foreign
		192-05-8769		1)SM 2 F	8	32	YRS.	MONTHS	YS HOUR	S MIN,		JLY 23,	1912		ENNSYLVANIA
L	~	9a. FACILITY NAME (If not institution		treet and number)				9b. CITY, TO			EATH		9c. COU	NTY OF D	
	ē	LEVINDALE						BAL	TIMOR	E					
	DIRECTOR		. COUNTY	LTIMORE			10c. CITY, TOWN OR LOCATION BALTIMORE								10d. INSIDE CITY LIMITS? 1 YES 2 NO
	¥	10e. STREET AND NUMBER					101. ZIP CODE					10g. CITI	ZEN OF	WNAT COUNTRY?	
	FUNERAL	5 COBBLER C	COUR				21208						USA		
		11. MARITAL STATUS 1 Never Married 2 Marri	fed	12. WAS DECEDEN				13. WAS	DECENDEN	OF NISPAI	NIC OR	IIGIN? (Specify Ye	or No-	14. RACI	E — American Indian, k, White, atc.
	_β	3 Widowed 4 Divorced		IF YES, GIVE Y			MNO If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: Specify:					lly:			
- 1		15. DECEDENT'S EDUCATION 18a. (CEDENT'S	USUAL OCCU	PATION			165 KIND OF BIL	SINESS /IND	HETEV	WHITE
		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)													
	COMPLETED	Elementary/Secondary (0-12)		5+	"		CHE	EMIST				EDG	FWOOT) AP	SENAL
	8	17. FATHER'S NAME (First, Middle,	Last)				-		18. M	TNER'S NA	ME (FI	rst, Middle, Maiden		י אויי	OBNAL
	BE	MEYER GOLDE	ENSO	V						JAN	EF	. FEINE	ERG		
	10	194. INFORMANT'S NAME (Type/PI ISABEL B. PR				19b.				ber or Rural	Route I	Number, City or Tow	n, State, Zip	Code)	8
		20e. METNOD OF DISPOSITION 1 Comment of Disposition Date Dat													
	ı	21. BIGNATURE OF FUNDAL BERVICE LICENSEE													
		SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, Approximeta													
		23. PART I. Enter the disees ehock, or heart	tes, or o	complications the	t caused	the des	sth. Do n	ot enter the	mode of	lying, euc	h es	cardiac or resp	iratory srr	est,	Approximeta
		IMMEDIATE CAUSE (Finsi disease or condition resulting in desth)	31	. les			ry	_ 7	01	. 2					Onset and Death
	2	disease or condition resulting in desth) e. Les ruelory Jaulure DUE TO OR AS A CONSEQUENCE OF:												_	
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	CAL CERTIFICATION	that initisted events	ondition	oue to	(OR AS A	CONSEO	UENCE OF	7):				I. 24e. WAS AN		24b	WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
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The party of the p	MPHYSICIAN: MEDICAL	PART II Other significant or Could II Other significant or Could II Other significant or Could II Other II Other Significant or Could II Other II O	ing attention of not be miled	DUE TO d. B contributing to Clan: To the beel of a	death but the service of the service	at not re	DOA 28b. TIMI	OTHER: 4 Nursing E OF 26c URY M 1 Recent, factory,	6. PLACE OF Nome 5 INJURY AT WORK? YES 2 office date and pla	DEATN (Ch Residence	Part Pa	PERFOI 1 YES 2 Ny one) Other (Specify) DESCRIBE NOW I LOCATION (Street City or Town, State)	NJURY OCC	OVRED or Rural I	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within a form of the HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remoral.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitied at once.

•	FOR STATE REGISTRAR
4	1. DECEDENT'S NA
ľ	4. SOCIAL SECURI
i	220-03-6
I	9a. FACILITY NAME
	Saint .
K	RESIDENCE C
١	10e. STATE
I	M 7

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_	nedistrian			CHIL	CALE	UF	DEAL	п	REG. NO).		
	1. DECEDENT'S NAME (First, Middle, Last) MARTHA			HEI	NZ				2. DATE OF DEATH	4 198	4 ^{YEAR}	3. TIME OF DEATH 8:50 am
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	est birthday)	IF UNDER	1 YEAR	IF UNDER 2		7. DATE OF BIRTH		8. BIRTH	PLACE (State or Foreign
	220-03-6173 9a. FACILITY NAME (If not institution, give s	1 □ M 2 🎇 F	88	YRS.	MONTHS	DAYS	HOURS	MIN.	Jan 3, 19		Ger	many
e l	Saint Joseph Hos	pital			9b. CITY,		R LOCATIO			9c. COL	Balti	MOPE
ן ט	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT											
. DIRECTOR	Maryland Ba	ltimore		10c. CIT	r, town o TOWS		ION					10d. INSIDE CITY LIMITS? 1 X YES 2 NO
₹	10e. STREET AND NUMBER					101	ZIP CODE			10g. CIT	IZEN OF W	HAT COUNTRY?
FUNERAL	2300 Dulaney Val							204		USA		
B	1 Never Merried 2 Merried 3 X Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2 X	NO	1	f yes, spe	ENDENT OF Helfy Cuben	, Mexican,	C ORIGIN? (Specify Yo., Puerto Ricen, etc.)	ea or No— 14. RACE — American Indian, Black, white, atc. Specify: White		
ᇜ	15. DECEDENT'S EDU (Specify only highest grade	CATION	16a. D	ECEDENT'S	CEDENT'S USUAL OCCUPATION 16t				16b. KIND OF BU	JSINESS/IN		
	Elamentary/Secondary (0-12)	College (1-4 or 5 +	- ti	fe. Do NOT us	ive kind of work done during most of working Do NOT use retired.)				1			
COMPLETED	8			Home	Homemaker				Own			
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Mald							
8	Albert Bachmaier								ina Breit			
2									oute Number, City or To		p Code)	
	Else Seto			3904	Gle	nmor	e Ave	e., 1	Baltimore	, MD	212	06
	1 Buriel 2 X Cremetion 3 Removat from Stata cemetery, cre Green				DATE OF DISPOSITION (Name of only or other place) Mount Crematory 12/16 Baltimore, MI							
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY ALTENBURG FUNERAL HOME, P.A.							
	1/ Rouse		6	009	Harfo	ord I	Rd., Balt	imore	e, MD	21214		
	23. PMT I. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, pr heart feliure. List only pne ceuse of each line. IMMEDIATE CAUSE (Final disease or condition ————————————————————————————————————						Approximata Intervel Between Onset and Deeth 2 DYS.					
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST	POVAS EQUENCE OF	DVASCULAR ACCIDENT UENCE OF):						2 WKS.			
	PART II. Other significent condition	s contributing to	death but not	resulting i	n the un	derlying	ceuse of	ven in P	art I. 24a. WAS A	V ALITOPSY	24h	WERE AUTOPSY FINDINGS
: MEDICAL	CONGESTIVE HEAD				-					RMED?		AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO
A	25. WAS CASE REFERRED TO MEDICAL					28 Pt	ACE OF DE	ATH /Choc	th nath ann)			
3	1 VES 2 NO	NOSPITAL:	EB/Outpetlant	3 🗆 DOA	OTHER	R:						
PHYSICIAN: M	27. MANNER OF DEATH	28e. DATE OF (Month, De	INJURY	26b. TIM		28c. INJ	JRY AT		Other (Specify) 28d. DESCRIBE HOW	INJURY OC	CURED	
ED BY	2 Accident Investigation 3 Suicida 5 Could not be 4 Homicide determined	26e. PLACE Of building,	F INJURY — At hetc. (Specify)	nome, tarm, s	treet, facto				26t. LOCATION (Street City or Yown, State	and Numbe	er or Rural F	loute Number,
MPLE		CIAN: To the best of	my knowledge, o	lasth occurre	d at the ti	me, date	and place,	end due to	o the cause(s) and ma	nner es ste	ited.	
CO	one) 2 MEDICAL EXAMINE	R: On the beala of ex	samination and/or	r investigatio	n, in my o	pinion, d	eth occure	d at the ti	me, date and place, e	nd due to t	he ceuse(s) end menner as stated.
#	29b. SIGNATURE AND TITLE OF CERTIFIED	P. Dr	non		n.1	0	29c, LICEN		BER	29d. DAT	6	(Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHE BEATRIZ P. DIZON,	M.D., 762	O YORK	EM 27) (Type.	Print)	WSO	N, MD), 212	04	1 /(1117
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE											
	DEC1 5 1994 A											

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

hospital or attending physician. use as the ò funeral director, page 5 should be detached Page 6 may be retained by the the attending physician and completely filled in by the Merital Hygene prior to burial, cremation, or removal. has been s Dept. of H OR ATTENDING PHYSICIAN: The law 23 this certificate hi 10 DIRECTOR: After the hours after death was

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31. DATE FILED (Month, Day, Year)

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32. REGISTRAR'S SIGNATURE Savilson-Rendall

ITEM: 17. PER F.H. FILM G-718 12/15/94 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH THOMAS F. HAMILTON JR. NOV. 26,1994 1818 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. last birthday) 5. SEX 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 - F 57 MD 216322793 8/4/37 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH ST. AGNES HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD BALTIMORE 1 X YES 2 NO 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 4506 MOUNTVIEW RD. 21229 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 NO 1 Never Married 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: AFR. AMERICAN 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5 +) BAKER 17. FATHER'S NAME (First, Middle, Last) THOMAS F. HAMILTON SR. 18. MOTHER'S NAME (First, Middle, Malden Surname) THOMAS F. HANILTON SR. MARTHA LEE JORDAN 19s. INFORMANT'S NAME (Type/Frint) 19th MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Gode) ISABELLE HAMILTON 4506 MOUNTVIEW RD. BALTO, MD 21229 Ma. METHOD OF DISPOSITION

1 N Burlal 2 □ Cremetion 3 □ 205 PLACE AND DATE OF DISPOSITION / Name of 20c. LOCATION --- City or Town, State DATE CATHEDRAL CEM. 4 Donation 5 Li Olban Manage 21 ANDHATURE OF FUNERAL RESIVICE LIGHT 12/2/94 BALTO. 22. NAME AND ADDRESS OF FACILITY ESTEP BROS. FUNERAL HOME P.A. 1300 EUTAW PLACE BALTO. MD 21217 not enter the mode of dying, such as cardiac or respiratory arrest, cations that gaused the death. Do shock, or heart failure. List only Interval Between IMMEDIATE CAUSE (Final Onset and Death Esophageal Carcinonia disease or condition regaliting in death) DUE TO JOR AS A CONSEQUENCE OF Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE delydra fine 1 TYES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL OTHER: 1 TYES 25 NO ☐ Inpatient 2 5R/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO 2 Accident 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, farm, atreet, fectory, office building, etc. (Specify) 3 Suicide 6 Could not be 4 Homicide determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end manner as atated. 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(e) end menner ee stated. 29h. SIGNATURE AND TITEE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) AV. Baltomore May land

BALTIMORE. MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

3635 Old 31. DATE FILED (Month, Day, Year) ULU 1 5 1994

32. REGISTRAR'S SIGNATURE

DELINIONE, MAIN EAST DELINIONE	in 24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at ence
	TO THE HOSPITAL OR ATTENDING PHYSICIAM: The law requires that the death certificate be executed within ear hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furbe filled within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If them 28 is marked, or flem 23 shows any injury, or other traumatic event, the medical examinant must be notified at ence.

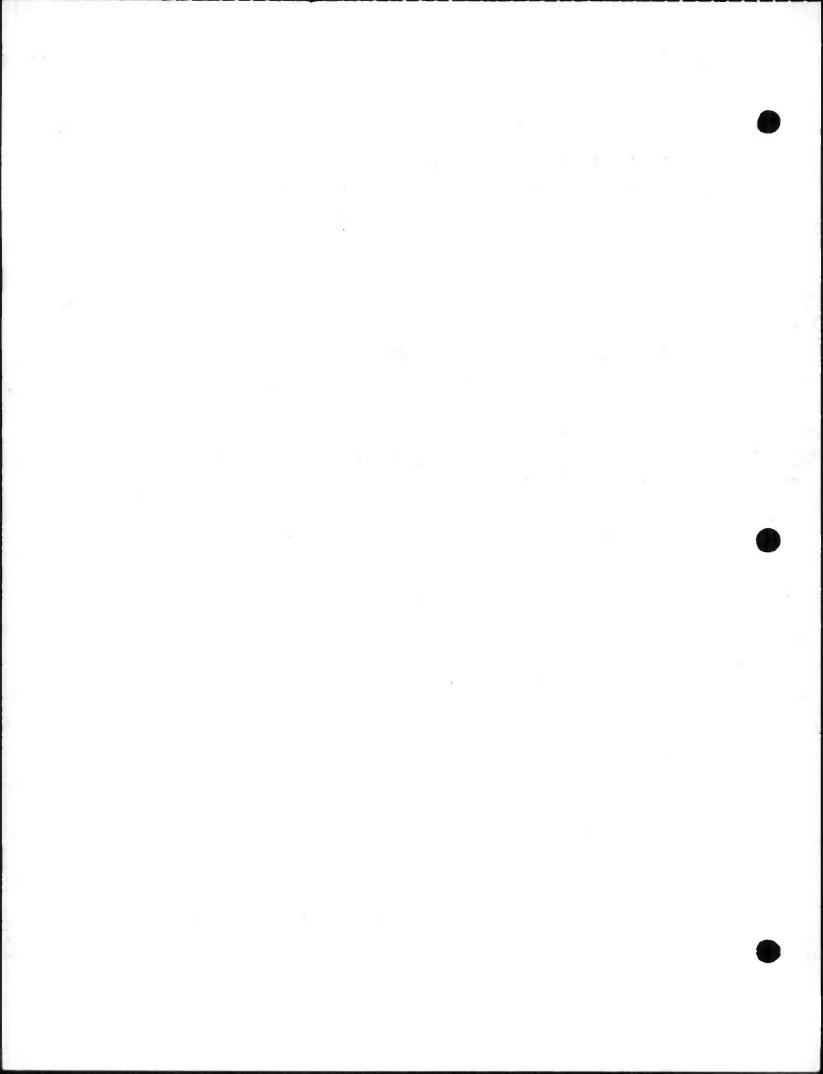
	Item#16b Per F	H. Fil	m# G-7	718	12/	15/94	R.M.		94	3	1229
	1 - FOR REGISTRAR	STATE OF MA				OF HEALTH		MENTAL HYGIE			
	1. OECEDENT'S NAME (First, Middle, Last)		11 1	7 3 3				2. DATE OF OEATH	DAY	YEAR. 3	. TIME OF DEATH
	Kena t.		HOSWIT	2				DECEMBER	10/	994	58 M
			. AGE (In yrs. last I		IF UNDER	DAYS HOURS	R 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		Country)	ACE (State or Foreign
	215-03-7416 9a. FACILITY NAME (If not institution, give stre-	1 🗆 M 2 🙀 F	88	YRS.				DEC. 25,			YLAND
<u>~</u>		et and number)			9b. CITY	, TOWN OR LOCA		EATH	9c. COUP	NTY OF DEA	TH
18	3110 BONNIE ROAD			BALTIMORE							
DIRECTOR	10a. STATE 10b. COUNTY			10c. CITY, TOWN OR LOCATION						1	0d. INSIDE CITY LIMITS?
	MARYLAND			BALTIMORE						1	□XES 2 □ NO
FUNERAL	100. STREET AND NUMBER 3110 BONNIE ROAD			10f. ZIP CODE 21208					10g. CITIZEN OF WHAT COUNTRY?		
N.		2. WAS DECEDENT I	TVER IN II O ARM						USA		
	1 Never Married 2 Married	FORCES? 1	YES 2 THO	NO If yes, specify Cuban, Mexicen, Puerio Rica					Ify Yes or No— 14. RACE — American Indian, Black, White, etc.		
8	3√XWidowed 4 □ Divorced	IF YES, GIVE WAR	OH UATES	1 TES 2 X NO Specify:						Specify:	WHITE
	15. DECEDENT'S EDUCA (Specify only highest grade co	TION (mpleted)	18a. DECI	(Give kind of work done during most of working					USINESS/IND	USTRY	
	Elementary/Secondary (0-12) College (1-4 or 5+) HOME										
COMPLETED	1 HOUSEWIFE								-AT	HOMR	E
	17. FATHER'S NAME (First, Middle, Lest)		Don			18. MO		ME (First, Middle, Maide		TEST	
BE	ISRAEL 19a. INFORMANT'S NAME (Type/Print)		FOR 19h		ADDRES	S (Street and Numb	Al	NN S. Poute Number, City or To	PENETS		
5	MR. ALAN HORWITZ							IVE BALTIM			200
	20a. METHOD OF DISPOSITION		20b. PLACE AN	ID OATE	OF DISPOS	SITION (Name of	W DI		OCATION —		
	1 Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	al from State	HEBRE			SHIP -	12-	-12-94 BA	LTIMO	RE, M	ID
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE /			22.	NAME AND ADDR	ESS OF FA	CILITY		1427 11	
	► You! (180)	1 Li	_					& BROS.,		THORE	WD 01015
	23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or reapiratory srrest, shock or heart failure. List oply one cause on each line. Approximate Interval Batween										
	Interval Between Onset and Death Onset and Death										
	disease or condition a. ON GOLIVE HEAVY FAILURE DUE TO (OR GO A CONSEQUENCE OF): HASON LITTUS										
NO	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): ### A SCW DUE TO (OR AS A CONSEQUENCE OF):										
RTIFICATION	if any, leading to immediata cause. Enter UNDERLYING	DOE 10 (0)	H AS A CONSEGU	JENCE U	r):						
띮	CAUSE (Disease or Injury that Initiated evanta	DUE TO (O	R AS A CONSEQU	JENCE O	F):						
ᇤ	reaulting in death) LAST								•		
디디	PART II. Other algnificant conditions	contributing to de	asth but not rea	Bulting	In the ur	derlying cause	alven In	Part i. 24s, WAS A	N ALTTOREY	045 W	ERE AUTOPSY FINDINGS
MEDICAL	Deneminatzhe			outrg	ACI	/A	givan in	PERFO	RMEO?	A	WAILABLE PRIOR TO OMPLETION OF CAUSE
	BIDAM	Debudi	die			V		1 □ YES	2 10	0	F DEATH?
	DID TOBACCO USE CONTRI	BUTE TO CAU	SF OF DEAT	H YE	S 🖂 I	NO IDVIN	CERTAIN	<u>-</u>		'	YES 2 NO
SICIAN:	25. WAS CASE REFERRED TO MEDICAL		28. PLACE				CLICIAII	101			
Sic		IOSPITAL:	R/Outpatient 3	DOA	OTHER 4 Nun		asidenca	8 Other (Specify)			
PHY	27. MANNER OF DEATH	28a. DATE OF IN (Month, Day,	JURY Year)	28b. TIM	E OF URY	28c. INJURY AT WORK?		28d. DEŞCRIBE HOW	INJURY OCC	URED	
BY	1 Netural 5 Pending 2 Accident Investigation				М	1 YES 2	□ NO				
	3 Suicide 8 Could not be 4 Homicide datarmined	28a. PLACE OF II building, ato	NJURY — At home (Specify)	e, ferm, i	streat, fact	ory, offica		28f. LOCATION (Street City or Town, State	and Number	or Rural Rou	te Number,
COMPLETED											
MPL	(Check only										
	20h SIGNATURE AND TITLE OF CERTIFIER	on the beats of exam	million and/or Inv		ri, in my o				-		
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	linn				29c. LIC	ENSE NUM	IBER	29d. DATE	SIGNED (M	Conth. Day, Year)
인	30. NAME AND ADDRESS OF PERSON WHO O	COMPLETED CAUSE	OF DEATH (ITEM:	27) (Type	Print)	1/	4/		1 /4	411/9	7
	3635 Old (a)	ut nd	Bron	16 .	m	1.	.4	mar.	Nous	m	0
		1	1201					1111101			

After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should after the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DING PHYSICIAN: The law requires that the death certificate be executed within 24 JIWSION OF VITAL RECORDS, P.O. BOX 68760,

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

	1. DECEDENT'S NAME (First, Middle, Last)						- 1	2. DATE OF DEATH		WEAR	3. TIME OF DEATH
	DAVID	В.	JO	NES			_ 1	DEC. 2	NY.	94	1306 PM
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	E (In yrs. last	birthday) II	UNDER t YEAR	IF UNDER 24 H		7. DATE OF BIRTH		8. BIRTI	HPLACE (State or Foreign
	219-18-1728	1,	69	YRS. MC	MTHS DAYS	HOURS M	PM,	(Month, Day, Year)	٠.	Count	(7)
	9a. FACILITY NAME (If not inatitution, give s		0,5		CITY TOWAY	OR LOCATION (JAN.22,192		DAY I	MON, OHIO
Œ	524 EAST 30TH	,		1 "		IMORE			VC. COU		
DIRECTOR	RESIDENCE OF DECEDENT	DINEEL			DALI.	LITORE	CI.	1 1		n/a	3
	10a. STATE 10b. COUNT	γ		10c. CITY, T	OWN OR LOCA	ATION					10d. INSIDE CITY
1 등	MARYLAND	n/a			BALTI	MODE					10d. INSIDE CITY LIMITS? 1 AZYES 2 NO
	10e. STREET AND NUMBER	11/ 0				of, ZIP CODE			40- 017	17511 05 1	WHAT COUNTRY?
FUNERAL											
W	524 E. 30 TH					212				ITED	STATES
5	1 K Never Married 2 Married	12. WAS DECEDENT EVEL FORCES? 1 X X 1	S 2 N		13. WAS DE	CENDENT OF HI pecify Cuban, M	ISPANIC lexican,	ORIGIN? (Specify Yas Puarlo Rican, etc.)	or No-	14. RACI Blac	E — American Indian, k, White, atc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OF	DATES		1 🗆 YE	S 2 NO S	Specify:			Spec	**:WHITE
ED E			T		1						
1 2	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DEC	EDENT'S US	NT'S USUAL OCCUPATION d of work done during most of working Of use retired.) 16b. KIND OF BUSINESS/I					DUSTRY	
LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.						- /-		
₽ E	HIGHSCHOOL - LABORER n/a										
COMPL	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)										
BE	CHARLES JONES					1	MAR:	y sheffli	ER		
	19a. INFORMANT'S NAME (Type/Print)		19b.	MAILING AD	DRESS (Street	and Number or F	Rural Rou	ite Number, City or Town	, State, Zi	o Code)	
유	MARY ANN WILLIA	AMSON		1203	SOUTH	MAIN	ST	, EDENBURG	G, V:	IRGI	NIA 22824
	20s. METHOD OF DISPOSITION	1:	20b. PLACE A	ND DATE OF D	ISPOSITION /A	iame of		DATE 20c, LO	CATION -	City or To	own, Stata
	1 Donation 5 Other (Specify)		cemetery, cren	natory or other	place)						
	21. SIGNATURE OF FUNERAL SERVICE LIG	CENSEE	MEAI	XWRID		ORTAL.		12-119	BA	TT, TW(DRE, MD
	0 1 5	26				IND ADDITEGO O)				
	Demand B	TIMON			WM.	C. MAR	CH I	FH1101	E. I	NORTI	H AVENUE
	23. PART I. Enter the diseases, or o	complications that caus	sed the des	th. Do not	enter the m	ode of dying,	auch a	na cardiec or reepi	ratory ar	reat,	Approximate
	ehock, or heart failure. We only one cause on each line.										
	IMMEDIATE CAUSE (Final disease or condition Addition and Death disease or condition Addition										
	resulting in deeth) a. HTTW SCLLEGTC CUICHTOUS CILLING WALRAN										
	DUE TO (OR AS A CONSEQUENCE OF):										
Z	Sequentially list conditions b.										
ΙĔΙ	Sequentielly list conditione, DUE TO (OR AS A CONSEQUENCE OF):										
호	cause. Enter UNDERLYING CAUSE (Disease or injury										
	that initiated events DUE TO (OR AS A CONSEQUENCE OF):										
	resulting in death) LAST										
F	resulting in death) LAST	d									
CERTIFICATION		d									
	PART II. Other eignificent condition	d		7 1				ort I. 24a. WAS AN		24b	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO
		d. ne contributing to deeth Ogs/mck		7 1		ng couse give		ert I. 24a. WAS AN. PERFOR 1 9 YES 2	MED?	246	AVAILABLE PRIOR TO COMPLETION OF CAUSE
EDICAL		d. te contributing to deeth Classifum A		7 1				PERFOR	MED?	24b	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	PART II. Other eignificent condition	Asstruch	ve C	River	ny St	iscase		PERFOR 1 EYES 2 Pout	MED?	24b	AVAILABLE PRIOR TO COMPLETION OF CAUSE
MEDICAL	PART II. Other eignificent condition Charic DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	Asstruch	OF DEAT	H YES	ny St	J UNCER		PERFOR 1 EYES 2 Pout	MED?	245	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	PART II. Other eignificent condition Chronic DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	RIBUTE TO CAUSE	OF DEAT	H YES	NO [Check only one	UNCER	TAIN	PERFOR	MED?	24b	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 TAYES 2 \(\text{ NO} \)	RIBUTE TO CAUSE HOSPITAL: 1 InpetIent 2 ER/O	OF DEAT 26. PLACE utpatient 3	H YES OF DEATH	Check only one THER: Nursing Hor	UNCERT	TAIN	PERFOR 1 YES 2 Pout Other (Specify)	MED? NO Ral		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1. TYPES 2 \(\text{ NO} \) 27. MANNER OF DEATH	RIBUTE TO CAUSE	OF DEAT 26. PLACE ulpatient 3 [H YES	Check only one THER: Nursing Hor	UNCERT	TAIN	PERFOR	MED? NO Ral		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
MEDICAL	PART II. Other eignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VSS 2 NO 27. MANNER OF DEATH 1 Mentural 5 Pending Investigation	RIBUTE TO CAUSE HOSPITAL: 1 Inpetient 2 ER/O 28a. DATE OF INJUR (Month, Day, Year	OF DEAT 26. PLACE utpettent 3 [YY]	H YES OF DEATH (DOA 4 28b. TIME O INJURY	Check only one THER: Nursing Ho F 28c. IN W 1	UNCER	TAIN	PERFOR 1 YES 2 Pout Other (Specify)	MED? NO Ral		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
BY PHYSICIAN: MEDICAL	PART II. Other eignificent condition CMONIC DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Metural 5 Pending Investigation 3 Suicide 8 Could not be	RIBUTE TO CAUSE HOSPITAL: 1 Inpetient 2 ER/O	OF DEAT 26. PLACE utpatient 3 [y)	H YES OF DEATH (DOA 4 28b. TIME O INJURY	Check only one THER: Nursing Ho F 28c. IN W 1	UNCER	TAIN ince 8 2	PERFOR 1 YES 2 Pout Other (Specify)	MED? I NO Tal	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Metural 5 Pending Investigation	RIBUTE TO CAUSE HOSPITAL: 1 Inpatient 2 ER/O 288. DATE OF INJUR (Month, Dey, Year) 288. PLACE OF INJUR	OF DEAT 26. PLACE utpatient 3 [y)	H YES OF DEATH (DOA 4 28b. TIME O INJURY	Check only one THER: Nursing Ho F 28c. IN W 1	UNCER	TAIN ince 8 2	PERFOR 1 YES 2 Other (Specify) 8d. DESCRIBE HOW IN 8f. LOCATION (Street a	MED? I NO Tal	CURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	PART II. Other eignificent condition CMONIC DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Mertinal 5 Pending Investigation 3 Suicide 8 Could not be determined	RIBUTE TO CAUSE HOSPITAL: 1 Inpatiant 2 ER/O 288. DATE OF INJUR (Month, Day, Year 288. PLACE OF INJUR building, stc. (S)	OF DEAT 26. PLACE utpetient 3 [YY) RY — At horr	H YES OF DEATH O DOA 4 28b. TIME O DOA, farm, street	Check only one THER: Nursing Hor M 1 at, factory, office	UNCERTO	TAIN ance 8 2	Other (Specify) 8d. DESCRIBE HOW IN 8f. LOCATION (Street a City or Town, State)	MED? NO AJURY OC	CURED r or Rural I	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL	PART II. Other eignificent condition CMONIC DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Mertural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only) 1 CERTIFYING PHYSI	RIBUTE TO CAUSE HOSPITAL: 1 Inpetient 2 ER/O 28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJUR building, etc. (S)	OF DEAT 26. PLACE utpatient 3 [y) RY — At horr pecify) owiedge, dass	H YES OF DEATH OF DOA 4 28b. TIME OF DOA 6 100, form, street	Check only one THER: Nursing Hor M 1 at, fectory, office	UNCERTON TO THE STATE OF THE ST	TAIN ance 8 2 2 2 2 d due to	Other (Specify) 8d. DESCRIBE HOW IN 8f. LOCATION (Street a City or Town, State)	MED? NO A A A A A A A A A A A A A A A A A A	CURED r or Rural I	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN: MEDICAL	PART II. Other eignificent condition CMONIC DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAUSE HOSPITAL: 1 Inpetient 2 ER/O 28s. DATE OF INJUR (Month, Day, Year 28s. PLACE OF INJUR building, atc. (S)	OF DEAT 26. PLACE utpatient 3 [y) RY — At horr pecify) owiedge, dass	H YES OF DEATH OF DOA 4 28b. TIME OF DOA 19b. (form, street)	Check only one THER: Nursing Hor M 1 at, fectory, office	UNCERTO	TAIN 2 2 d due to at the tim	Other (Specify) 8d. DESCRIBE HOW IN 8f. LOCATION (Street a City or Town, State) the cause(s) and manne, data and place, and	MED? NO A A A A A A A A A A A A A A A A A A	CURED r or Rural I	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
E COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other eignificent condition CMONIC DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Mertural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only) 1 CERTIFYING PHYSI	RIBUTE TO CAUSE HOSPITAL: 1 Inpatient 2 ER/O 28a. DATE OF INJUR (Mornit), Day, Year 28a. PLACE OF INJUR building, etc. (S)	OF DEAT 26. PLACE utpatient 3 [y) RY — At horr pecify) owledge, dass tion and/or in	H YES OF DEATH (DOA 4 28b. TIME of DINJURY DOB, form, street	Check only one THER: Nursing Hor M 1 at, fectory, office	UNCERTON TO THE STATE OF THE ST	TAIN ance 8 2 D 2 d due to at the time time the time the ti	PERFOR 1 YES 2 Other (Specify) 8d. DESCRIBE HOW IN 8f. LOCATION (Street a City or Town, State) the cause(s) and manne, data and place, and	MED? NO AJURY OC and Number ner as start d due to til 29d. DAT	CURED r or Rural II ted. this cause(s	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number,
BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other eignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAUSE HOSPITAL: 1 Inpettent 2 ER/O 288. DATE OF INJUR (Morith, Dey, Yest) 288. PLACE OF INJUR building, etc. (S) ICIAN: To the best of my known. R. On the basis of exeminar	OF DEAT 26. PLACE utpettent 3 TY TY Owledge, das titon and/or in	H YES OF DEATH (DOA 2 28b. TIME O INJURY The farm, street	Check only one THER: Nursing Hor M 1 at, fectory, office t the time, dat	UNCERTO	TAIN ance 8 2 D 2 d due to at the time time the time the ti	PERFOR 1 YES 2 Other (Specify) 8d. DESCRIBE HOW IN 8f. LOCATION (Street a City or Town, State) the cause(s) and manne, data and place, and	MED? NO AJURY OC and Number ner as start d due to til 29d. DAT	CURED r or Rural II ted. this cause(s	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number;
E COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other eignificent condition CMONIC DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAUSE HOSPITAL: 1 Inpettent 2 ER/O 288. DATE OF INJUR (Morith, Dey, Yest) 288. PLACE OF INJUR building, etc. (S) ICIAN: To the best of my known. R. On the basis of exeminar	OF DEAT 26. PLACE utpatient 3 [YY) PRY — At horr pecify) Owledge, dase tion and/or in	H YES OF DEATH (DOA 4 28b. TIME O INJURY The form, street The occurred a reading attorn, in	Check only one THER: Nursing Hor F	UNCERTON TO THE STATE OF THE ST	TAIN 2 2 2 d due to at the time E NUMBE M •]	PERFOR 1 YES 2 POWN Other (Specify) 8d. DESCRIBE HOW IN 8f. LOCATION (Street a City or Town, State) the cause(s) and manne, data and place, and	MED? NO NO NO NO NO NO NO NO NO N	CURED r or Rural II ted. ha cause(a	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, a) and manner as estated, (Month, Day, Year) 3,1994
BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other eignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAUSE HOSPITAL: 1 Inpatient 2 ER/O 28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJUR building, atc. (S) ICIAN: To the best of my known. ER: On the basis of exeminar R O COMPLETED CAUSE OF I	OF DEAT 26. PLACE utpatient 3 [Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	H YES OF DEATH (DOA 4 28b. TIME O INJURY The form, street The occurred a reading attorn, in	Check only one THER: Nursing Hor F	UNCERTON TO THE STATE OF THE ST	TAIN 2 2 2 d due to at the time E NUMBE M •]	PERFOR 1 YES 2 Other (Specify) 8d. DESCRIBE HOW IN 8f. LOCATION (Street a City or Town, State) the cause(s) and manne, data and place, and	MED? NO NO NO NO NO NO NO NO NO N	CURED r or Rural II ted. ha cause(a	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, a) and manner as estated, (Month, Day, Year) 3,1994
BE COMPLETED BY PHYSICIAN: MEDICAL	PART II. Other eignificent condition DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	RIBUTE TO CAUSE HOSPITAL: 1 Inpettent 2 ER/O 288. DATE OF INJUR (Morith, Dey, Yest 288. PLACE OF INJUR building, etc. (S)	OF DEAT 26. PLACE utpatient 3 [Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y Y	H YES OF DEATH (DOA 4 28b. TIME O INJURY The form, street The occurred a reading attorn, in	Check only one THER: Nursing Hor F	UNCERTON TO THE STATE OF THE ST	TAIN 2 2 2 d due to at the time E NUMBE M •]	PERFOR 1 YES 2 POWN Other (Specify) 8d. DESCRIBE HOW IN 8f. LOCATION (Street a City or Town, State) the cause(s) and manne, data and place, and	MED? NO NO NO NO NO NO NO NO NO N	CURED r or Rural II ted. ha cause(a	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, a) and manner as estated, (Month, Day, Year) 3,1994



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.

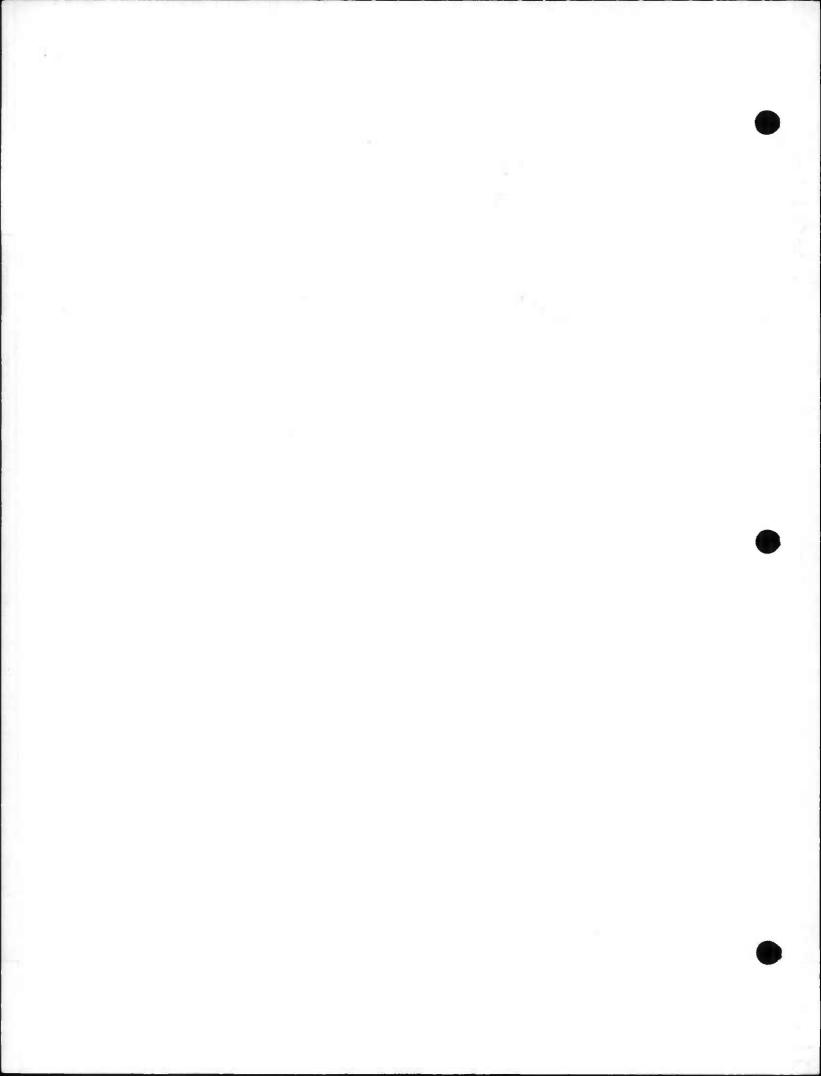
TO THE FUNERAL OHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Oept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Inlury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	* REGISTRAR		CEI	KITE	CATE O	PUEA	IH	RE	EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	Ethel Aug	usta Jo	hnso	on			2. DATE OF O MONTH Decemi	DA		YEAR 1994	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		AGE (In yrs. last t		IF UNDER 1 YEAR	IF UNDE	R 24 HRS.	7. DATE OF B		11/		PLACE (State or Foreign
	190 20 0153	t □ M 2 🔀 F	73	YRS.	MONTHS DAYS		MIN.	(Month, Day)	(Year)	1921	Country	st Virginia
	9e. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY, TOW	OR LOCAT	ION OF DE	ATH		9c. COU	NTY OF D	
DIRECTOR	North Arundel	Hospital			Glen	Burni	9			Anr	ne Ar	undel
l m	10a. STATE 10b. COUNTY			10c. CITY	, TOWN OR LO	ATION					T	10d. INSIDE CITY
		e Arundel		G1	en Bur	nie						LIMITS? 1 ☐ YES 2 ☑ NO
A A	10e. STREET AND NUMBER					of. ZIP COD	E			10g. CIT	IZEN OF W	HAT COUNTRY?
FUNERAL	1213 Aster Driv	re				210	061			Ţ	J.S.A	
15	tt. MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARM	ED				IIC ORIGIN? (Sp		or No-	14. RACE	- American Indian,
BY F	1 Never Married 2 Merried 3 X Widowed 4 Divorced	FORCES? 1 []		MNO If yee, specify Cuben, Mexicen, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: Specify:								
COMPLETED	15. DECEDENT'S EOUC (Specify only highest grade	(Gha	kind of w	USUAL OCCUPA	TION	ing.	16b. KINI	OF BUS	INESS/IN	DUSTRY	White	
LET	Elementery/Secondary (0-12)	life. D	o NOT us	e retired.)	nost or work	719		1000				
MP	47 CATHED O MARK (Fine Asidella Laux)		HO	usew	ire					laker	-	
	17. FATHER'S NAME (First, Middle, Lest)			16. MOT		me (First, Middle ara Sp						
BE	19a. INFORMANT'S NAME (Type/Print)			MAILING	ADDRESS (Street	t and Numbe		Route Number, Ci			Codel	
2	Patricia Seitle	r			11th S							land 21122
	200. METHOD OF DISPOSITION				FDISPOSITION	-	<u> </u>	OATE			City or To	
	1 Donation 5 Other (Specify)	oval from State	cemetery, cremi	atory or other	her place) 1 Cemet	Orv		1 1111				Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	ocuar	****	22. NAME	AND ADDRE		CILITY				
	George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 2											
	23. PART I. Enter the diseases, or c	omplications that ca	used the deet	th. Do n	ot enter the r	node of dy	ing, suci	haa cerdiec	or respir	TIMOT o	reat.	Approximate
	shock, or haart fallure. I	List only one causa	on aach line.								,	Interval Batween Onset and Death
	disease or condition											
	DUE TO (OR AS A CONSEQUENCE OF):											
Z	Construction that are allet as a	mob.	MI									
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate	DUE TO (OR	AS A CONSEOU	IENCE OF):							
2	cause. Enter UNDERLYING CAUSE (Disease or Injury	. Habel	AS A CONSEQU	ENCE OF								
Ē	that initiated eventa resulting in death) LAST	1/200	AS A CONSECU	ENGE OF	J.							
		1. 180/10	Um									
	PART II. Other significent conditions	a contributing to dea	ath but not rea	sulting i	n the underly	ng ceuse	given in	Part I. 24a.	WAS AN		24b.	WERE AUTOPSY FINDINGS
EDICAL								10	PERFOR			AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?
MEC												t TYES 2 NO
ž	DID TOBACCO USE O	CONTRIBUTE T	O CAUSI	E OF	DEATH	YES [] NC					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		/	28.		DEATH (Ch	eck only one)				
ZSI	1 TYES 2 NO	1 Inpetient 2 ER	VOutpatient 3 €	DOA	OTHER: 4 - Nursing H	ome 5 🗆 R	esidence	6 Other (Spe	ecity)			
H	27. MANNER OF CEATH	28e. DATE OF INJ (Month, Day, Y	URY 6ar)	28b. TIME		NJURY AT YORK?		28d. OESCRIB	E HOW IN	JURY OC	CUREO	
ΒX	1 Netural 5 Pending 2 Accident Investigation					YES 2 [NO					
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF IN building, etc.	JURY — At home (Specify)	e, ferm, s	treet, fectory, of	fice		281. LOCATION City or Tox		nd Numbe	r or Runit R	loute Number,
L.	290. CERTIFIER 1 D CERTIFYING PHYSIC	CIAN: To the best of my	knowledne dest	h occurre	d at the time d	te end plea	and due	to the councies	and me-	001 00 01	ted	
OMF	(Check only one) 2 MEDICAL EXAMINE) end manner es stated.
Ш	29b. SIGNATURE AND TITLE OF CERTIFIER	CA	21 1	1	1	29c. LIC	ENSE NUM	MBER		29d. DAT	E SIGNED	(Month, Day, Year)
TO B		_/	PC	11	(1) 		120	654		> /	2/12	194
	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE O	F DEATH (ITEM	27) (Type,	Print)	Cn		m			10	(1
	31. DATE FILED (Month, Day Year)	STATE OF LIDER	addadhe	-		2/)				2	100	/
	DECT 2 1994	,,,										



filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should on or removal.

	HISPITAL OR ATTENDING PHYSCHAL The law requires that the death certificate be executed within 2, Nours after death. Page 6 may be relained by the hos	THE FURENCE DIRECTOR. After this sertificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach attended in the formation or removal.	MPDRIANE II item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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T	曲	to the Futboau DRECTOR After this certificate has been signed by the attending physician and completely filled in by the futboard on the formation of the formation or removal.	OHT.
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	D 7 (-1 m:								2. DAT	E OF DEATH	W	YEAR	3. TIME OF DEATH
		llie)			lczj	/k			Dec	. 14,	1994		5:00 P. H
ļ	4. SOCIAL SECURITY NUMBER	6. SEX	6. AGE (In yrs. les		IF UNDER	1 YEAR	IF UNDER	24 HRS, MIN,	7. DATE	of BIRTH	206	8. BIRTHI	PLACE (State or Foreign
	217-68-1550	1 M 2 F	00	YRS.						.09 L			
æ	9e. FACILITY NAME (If not institution, give st						urni		ATH			NTY OF DE	Arundel Co
DIRECTOR	Bay Meadow Nursi	ng home			GTE	en D	urnı	.e			Al	ine a	arunder co
Ĕ	10a. STATE 10b. COUNTY				Y, TOWN		ION						10d. INSIDE CITY LIMITS?
5	Maryland			Bal	timo	ore							1 YES 2 NO
¥ I	10e. STREET AND NUMBER		•			101	ZIP COD						HAT COUNTRY?
<u> </u>	2126 Fleet Stre	eet					212	31			U	S.A	
BY FUNERAL	11. MARITAL STATUS 1 Marital 2 Merried 3 Widowed 4 Divorced	FORCES?	T EVER IN U.S. AR D YES 2 TH MAR OR DATES	ES 2 NO If yes, specify Cuben, Mexican, Puerto									
	15. DECEDENT'S EDUC	CATION	16a. DE	CEDENT'S	USUAL O	CCUPATIO	ON .		16	b. KIND OF BU	SINESS/INC	USTRY	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	Me	live kind of Do NOT u	ise retired.)		st of worldr	ng		0-200	T-	. 3	
를	4	0	Pac	king	g Hot	use				Canni	ng Li	10.	
Ö	17. FATHER'S NAME (First, Middle, Last)			16. MOTHER'S NAME (First, Middle, Melden Surneme) Katarzyna (Catherine) B) Br	vlewski			
W	Martin Krolczyk 19a. INFORMANT'S NAME (Type/Print)											ATEMORT	
2	Josephine Yuhar		807	221s	st S	t r ee	t,	Pasa	nber, City or Tow adena,	Mar;	ylan	d 21122	
	20e. METHOD OF DISPOSITION DE Burlel 2 Cremation 3 Remote Control of Other (Specify)	oval from State	20b. PLACE other pl	of dispo	sition (N	ame of cer us C	em .	Dec	.17	1994	Balt	City or To	wn, State d.
	21. SIGNATURE OF FUNERAL SERVICE OF George A. Web	awele	ons Inc.	0.0	- 4	_				& Sons Balto			231
	23. PART I. Enter the diseases, or of ahock, or heart feliure.				not ente	r the mo	de of dy	ing, auc	h aa ce	rdlec or reep	iratory ar	reat,	Approximate interval Batween
	IMMEDIATE CAUSE (Fine)												Onset and Death
ł	disease or condition resulting in death)	a +	HSP INLA	7710	NE	NO	201	NO	NI	7			48 HR
١		DUE TO	OR AS A CONSE	OUENCE C	OF):								
<u>ج</u> ا	Sequentially list conditions,	b											
F I	if eny, leading to immediate cause. Enter UNDERLYING	DOE IC	OR AS A CONSE	OUENCE C	<i>)</i> +):								
	CAUSE (Disease or injury that initieted events	cDUE TO	O (OR AS A CONSE	OUENCE C	DF):								1
CERTIFICATION	resulting in death) LAST	4											
뜅	DATE II AND THE MET A SECOND												
⋠∥	PART ii. Other aignificent condition	e contributing to	death but not	reculting	in the U	nderiyin	g ceuse	given in	Part I.	24a. WAS AN		246.	WERE AUTOPSY FINDINGS MAILABLE PRIOR TO
ă										1 TYES	2 DNO		OF DEATH?
ž									_				1 TYES 2 NO
ž		-											
ᅙ	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHE	R:	LACE OF E						
PHYSICIAN: MEDICAL	1 YES 2 NO	1 Inpatient 2	☐ ER/Outpetient :	26b. Til			10 5 □ R	esidence		her (Specify) ESCRIBE HOW	INLINEY OF	CUREO	
- 1	1 Natural 5 Pending		Day, Year)		JURY	W	YES 2	NO		EQUINDE 11011		001120	
BY	2 Accident Investigation 3 Suitcide 6 Could not be	28e. PLACE	OF INJURY - At h	ome, farm,	street, fac					CATION (Street		r or Rural F	Route Number,
	4 Homicide determined	building	i, etc. (Specify)						C	ty or Town, State)		
COMPLET	290. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of	of my knowledge d	eath occur	red at the	time det	end plan	e, end div	to the	ause(e) and ma	nner ee et	rted.	
Ž	CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. Comparison of the cause(e) end manner ee stated.												
	296. SIGNATURE AND TITLE OF CENTIFIER A HOUGH D. 296. LICENSE NUMBER 296. DATE SIONED (Month, Day, Year)												

02177

Attend 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

S.P. Mundra, 1600 Crain Highway, Glen Burnie, Md. 21122 2061

31. DATE FILED (Month, Day, Year)
DEC1 5 1994

32 REGISTRAR'S SIGNATURE

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FOR

* REGISTRAR		CERTIF		F DEATH	D MENI	REG. N	2		
1. DECEDENT'S NAME (First, Middle, Last)						TE OF DEATH			3. TIME OF OEATH
Michael	William	Ko	ordek		D	ec 1	4 1	994	0621 M
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	(In yrs. lest birthday)	IF UNDER 1 YEAR		(0.0-	E OF BIRTH		8. BIRTH	IPLACE (State or Foreign
213-32-7608	1X M 2 🗆 F	59 YRS.	MONTHS DAYS	HOURE MIN		onth, Day, Year) 2/ 09/	1935	Countr	Ď.
9a. FACILITY NAME (If not institution, give str	reet and number)		9b. CITY, TOW	N OR LOCATION OF	FOEATH	_,,		NTY OF D	EATH
5106 Wright	Avenue		Balt	imore					
10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LO	CATION					10d. INSIDE CITY
Md.			Baltimo	ore					LIMITS?
100. STREET AND NUMBER 5106 Wright Ave.				101. ZIP CODE 21205			10g. CIT	IZEN OF V	VHAT COUNTRY?
11. MARITAL STATUS	12. WAS OECEDENT EVER I	N U.S. ARMED	13. WAS D	ECENDENT OF HIS	PANIC ORIG	SIN? (Specify V	ea or No-	14. RACE	American Indian,
1 Never Married 2 X Married 3 Wildowed 4 Divorced	FORCES? 1 YES								t, Whita, etc.
15. OECEDENT'S EDUC (Specify only highest grade of	ATION completed)	16a. DECEDENT'S	Ida. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working				USINESS/INI		
Elementary/Secondary (0-12)	College (1-4 or 5+)	Draft	e retired.)	most or working		State			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S	NAME (First	t, Middle, Maide	a Sumamel		
August	Kord	lek			ephin		Mysz	kows	ki
19a. INFORMANT'S NAME (Type/Print)				et and Number or Ru					
Theresa Kordek		5106	wright	Ave. Ba	Itimo	re, Md	• 212	.05	
20a. METHOD OF DISPOSITION 123 Buriet 2 Cremetion 3 Remo 4 Donation 5 Other (Specify)	val from State cen	netery, cremetory or oti	her place)		12-		ocation — .1timc		
21. SIGNATURE OF FUNERAL SERVICE LICE		· Douring	22. NAME	ANO AODRESS OF	FACILITY				<u> </u>
* Kathlees) Welle	1/-		ld J. Wel S. Ches					d. 21231
23. PART I. Enter the dieeeses, or co	omplications that cause	the deeth. Do n	ot enter the n	node of dylng, s	uch es ce	ordiec or ree	piratory ar	rest,	Approximete
ishock, or heert failure. L IMMEDIATE CAUSE (Finel disease or condition resulting in death)		CUS ROT	ic ep	יסוסוסי	rDSc	mon	Dis	aD?	Interval Between Onset and Death
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST		CONSEQUENCE OF							
PART II. Other significent conditions	contributing to deeth b	ut not resulting in	n the underly	Ing ceuee given	In Pert I.	24a. WAS A		24b.	WERE AUTOPSY FINDINGS
						PERFO	PRMED?		AVAILABLE PRIOR TO COMPLETION OF CAUSE
				· · · · · · · · · · · · · · · · · · ·		Dia	2 COMO	.	OF OEATH?
DID TOBACCO USE CONTR	IBUTE TO CAUSE O	F DEATH YE	s \square NO	☐ UNCERTA	AIN 🗆	STICK	ied in	~	7 123 2 100
25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT	H (Check only on						
	HOSPITAL: 1 Inpetient 2 ER/Outp	etient 3 DOA	OTHER:	oma 5X Realden	ca 8 🗆 Otl	her (Specify)			
						ior (opposity)			
27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME		NJURY AT	28d. D	ESCRIBE HOW	INJURY OC	CURED	
14 Netural 5 Pending		28b. TIME	JRY V	NJURY AT WORK? YES 2 NO	28d. D	EŞCRIBE HOW	INJURY OC	CURED	
14 Netural 5 Pending Investigation 3 Suicide 8 Could not be	28a. DATE OF INJURY	- At home, ferm, at	JRY V	WORK? YES 2 NO	281. LC	ESCRIBE HOW DCATION (Street by or Town, State	and Number		oute Number,
1º Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be detarmined	28a. DATE OF INJURY (Month, Day, Year)	- At home, ferm, at	JRY V	WORK? YES 2 NO	281. LC	CATION (Street	and Number		oute Number,
1º Netural 2 Accident 3 Suicide 4 Homicide 29a. CERTIFIER (Check only) 1 CERTIFYING PHYSIC	28a. DATE OF INJURY (Month, Day, Year)	At home, ferm, at	JRY M 1	WORK? YES 2 NO fice ste and place, and c	281. LC	CATION (Street y or Town, State ause(a) and ma	and Number	or Rural R	
1º Netural 2 Accident 3 Suicide 4 Homicide 29a. CERTIFIER (Check only) 1 CERTIFYING PHYSIC	28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (SpecialAn: To the best of my know.	At home, ferm, at	JRY M 1	WORK? YES 2 NO fice ste and place, and c	281. LC	CATION (Street y or Town, State ause(a) and ma	and Number inner as stated	or Rural R	
1º Netural 2	28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Special Control of the besis of axamination) 1AN: To the besis of axamination	— At home, farm, at ledge, death occurred and/or investigation	M 1 Creet, factory, of	WORK? YES 2 NO Note and place, and c, death occured at t	281. LC C/d due to the c the time, da	CATION (Street y or Town, State ause(a) and ma	and Number inner as stated due to the second du	or Rural R	and manner se stated.
19 Netural 2 Accident 3 Suicide 4 Homicide 8 Could not be detarmined 298. CERTIFIER (Check only 1 CERTIFYING PHYSIC one) 2 MEDICAL EXAMINER	28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Special Control of the besis of axamination) 1AN: To the besis of axamination	At home, farm, at ledge, dasth occurren and/or investigation	IRY M 1 Circet, factory, of d at the time, ds t, in my opinion,	NORK? YES 2 NO Notice Ite and place, and c, death occured at 1 29c. LICENSE P	281. LC C/d due to the c the time, de	euse(s) and mitte and place, a	and Number inner as state and dus to the	or Rural A	and menner se stated. (Month, Day, Year)

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within or hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

DHMH-18 Rev 1/69

physician. bunal-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

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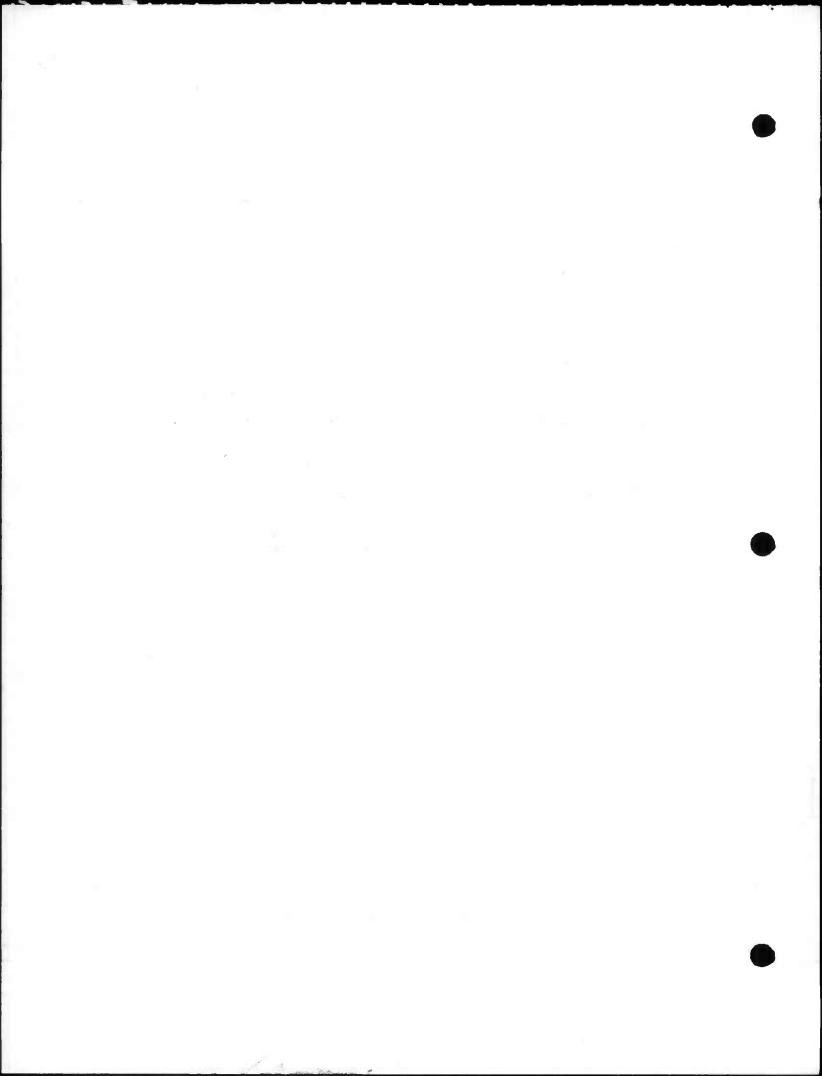
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending to	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TH OT	日子	IMPO

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

_	REGISTRAN	OLITITI	CAIL	F DEATH	REG. NO	4.			
	1. DECEDENT'S NAME (First, Middle, Last) REBECCA	LANDI	_		2. DATE OF DEATH MONTH D		3. TIME OF DEATH		
)R		AGE (In yrs. last birthday)	IF UNDER 1 YEA	R IF UNDER 24 HRS.	7. DATE OF BIRTH	3 99			
	578-09-7462 1 1 M 25 E		MONTHS DAY	B HOURS MIN.	(Mooth, Day, Year)	23	BIRTHPLACE (State or Foreign Country)		
	98. RACILITY NAME (If not distribution, give street and number) 99. COUNTY OF DEATH 90. COUNTY OF DEATH HOWALD 100 ACCOUNTY OF DEATH HOWALD								
2	RESIDENCE OF DECEDENT								
BY FUNERAL DIRECTOR	100. STATE MD 10b. COUNTY HOWARD 10c. CITY, TOWN OR LOCATION COLUMBIA 10d. INSIDE CITY LIMITS? 1 □ YES 2 💆 NO								
	5400 VANTAGE POINT A		2104	4	10g. CITIZEN OF WHAT COUNTRY?				
	11. MARITAL STATUS 1 Never Married 2 Married 3 Midowed 4 Divorced 12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR	If yes,	Specify Cuben, Mexica (ES 2 NO Specific						
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16e. DECEDENT'S U	JSUAL OCCUPA	TION in most of working	16b. KIND OF BU				
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) HOMEMAKER OWN HOME								
SON	17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Surname)								
BE	UNKNOWN								
2	190. INFORMANT'S NAME (Type/Print) CHARLES N. SEASHORE (NEPHEW) 10001 WINDSTREAM DRIVE COLUMBIA MD 21044								
	20e. METHOD OF DISPOSITION 1 General Surface								
	21. SIGNATURE OF FUNCTION SERVICE LICENSEE	CAD LY	DLYR WITZKE FUNERALHOM						
23. PART I. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,									
	Approximate shock, or heart feliura. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death								
ļ	disease or condition								
_	DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING								
SE!	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):								
Ä	reaulting in death) LAST								
. 1	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS								
EDICAL	ALZHEIDER DENTIA PERFORMED? AMILABLE PRIOR TO COMPLETION OF CALL OF DEATH? 1 YES 2 STO OF DEATH?								
Σ	1 YES 2 NO								
SICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check cold cold)								
밇	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1								
PHY	27. MANNER OF DEATH 28e. DATE OF IN.	IURY 28b, TIME	OF 28c.	NJURY AT WORK?	28d. OESCRIBE HOW I	NJURY OCCURE	D		
BY	1 Natural 5 Pending 2 Accident Investigation		M 1	YES 2 NO					
COMPLETED	3 Suicide a Could not be datermined 26e. PLACE OF II building, atc	reet, factory, or	fice	281. LOCATION (Street end Number or Rural Route Number, City or Yown, State)					
<u> </u>	29e. CERTIFIER (Check only (Check only) (Check only) (Check only) (Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated.								
Š ∥	one) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end manner se stated.								
띪	29c. LICENSE NUMBER 29d. DATE SIGNED (Month 29d. DATE SIGNED (MONTH 29d. DATE SIGNED (MONTH 29d. DATE SIGNED (MONTH 29d. DATE SIGNED (MONTH								
임	30. NAME AND MODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BLOG I LEVENE, MO 11055 Little PATURES PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) 32ADEGISTRAR'S GRAPUTS								
	delog L LEVINE, MO 11055 Little PATRIXER PK, COCOMORD Md 21044								
	DEC1 5 1994 July 32AREGISTRAR'S CONATURE DEC1 5 1994 July 32AREGISTRAR'S CONATURE OF THE PROPERTY OF THE PRO								





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for us be filled within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to burfal, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO.												
	1. DECEOENT'S NAME (First, Micdia, Lest) LOATS, WHILLIAM L. Loats 2. DATE OF DEATH MONTH DAY VEAR 12 94							TIME OF DEATH					
	4. SOCIAL SECURITY NUMBER 220–14–0395	5. SEX	6. AGE (In yrs. last bit	rthday) YRS.	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) April 7,1	924	a. BIRTHPLA Country) Mary	ACE (State or Foreign	
		9a. FACILITY NAME (if not institution, give street and number)		9b. CI			OWN OR LOCATION OF DE		EATH 9c. C		COUNTY OF DEATH		
DIRECTOR	Northwest Hospital Center				Randallstown					Baltimore			
E C		b. COUNTY	1	Oc. CIT	Y, TOWN (OR LOCAT	ION				10	d. INSIDE CITY	
P	Maryland Baltimore			Catonsville							LIMITS?		
MI	10e, STREET AND NUMBER			101. ZIP CODE				10g. CITI	IZEN OF WHA	T COUNTRY?			
BY FUNERAL	607 Meyers Drive			2122				21228	8		U.S.A	۷.	
	11. MARITAL STATUS 1 Never Married 2 Mar 3 Widowed 4 Divorced	Never Married 2 Married FORCES? 1 ∑ YES 2 ☐								e or No— 14. RACE — American Indian, Black, White, etc. Specity: White			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Gh			DENT'S	USUAL O	CCUPATIO	N et at wadrin	σ.	16b, KIND OF BU	SINESS/INC	DUSTRY		
<u> </u>	Elementary/Secondary (0-12)		+)				st of working	,					
JMC	12 E.			Lect	ric	ian	40. 10074		Const		ion		
	William A.								e E. Dey	Surname)			
O BE	19a. INFORMANT'S NAME (Type/						nd Number	or Rural R	loute Number, City or Tow				
5	Virginia Lo	ats (Wife)	17-46		-				nsville Ma	ryla	nd 212	228	
	20a. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☐ Cremation		20b. PLACE AND cemetery, cremate	DATE O	of DISPOS	ITION (Na	ment 2-1	16-9	OATE 20c. LO	CATION —	City or Town,	State	
	4 Donation 5 Other (Specify) Maryland Veterans Cemetery Owings Mills, Maryland									Maryland			
	22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes									l Homes			
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate									Maryland			
	snock, or near	reliure. Liet only one ce	use on each line.									Approximate Intervei Between	
	IMMEDIATE CAUSE (Finel disease or condition reaulting in death) • LIVE FAILURE Z° to Mulignant truck. One to (or as a consequence of): DESCHIMATED TURES (Finel disease) Onest end Deeth Ays Onest end Deeth Type Z° to Mulignant truck. DESCHIMATED Z° to Mulignant truck. DESCHIMATED TURES DESCRIPTION OF THE PROPERTY OF THE PRO									DAYS			
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Sequentielly list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Sequentielly list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d.								j					
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÷ M	1 YES 2 □ NO								YES 2 NO				
PHYSICIAN: MED	25. WAS CASE REFERREO TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one)												
rsic	1 YES 2 NO	HOSPITAL:	☐ ER/Outpatient 3 ☐	DOA	OTHER		5 🗆 Rea	aldence (B Other (Specify)				
H	27. MANNER OF OEATH 1 Netural 5 Perio	28a. DATE Of (Month, i		Bb. TIME	JRY	26c. INJU			28d. DESCRIBE HOW I	NJURY OCC	CUREO		
ВУ	2 Accident Inves	2 Accident Investigation			M 1 YES 2 NO								
COMPLETED	3 Suicide 6 Could not be determined 26e. PLACE OF INJURY — At home, 5 building, atc. (Specify)				ferm, street, factory, office			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
LEI I	29s. CERTIFIER 1 M CERTIFYING PHYSICIAN: To the heat of my knowledge death occurred at the time date and also and the set of the time date and the time date and the set of the time date and the time d												
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U U	29b. SIGNATURE AND TITLE OF CENTALISM 29c. LICENSE NUMBER 29d. DATE SIONEO (Month, Day, Year)												
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5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) SIMON CALLE, MD NO RTHWEST HOSE. CRUSER												
	31. DATE FILED (Month, Day, Year)												
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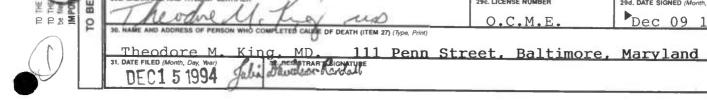
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Melvin Matthews Dec 09 1994 0133 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 1 X M 2 | F MIN 216-54-2336 27, Jan. Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Hopkins at Bayview N/A Baltimore 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD N/A Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 6123 Cardiff Avenue 21224 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 WNO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, Whita, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 X Married Specify: Black BY 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done life. Do NOT use retired.) Elamentary/Secondary (0-12) College (1-4 or 5 a) COMPL 10th n/a N/A Janitor 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Milton Matthews Magnolia BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Juanita Matthews 6123 Cardiff Avenue/Baltimore, MD 21224 20a. METHOD OF DISPOSITION
1 □ Burlel 2 X Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 4 Donetion 5 Other (Specify) Green Mount Cemetery 12/16 Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY March Funeral Home East 1101 E. North Avenue/Baltimore, MD 21202 23. PART i. Enter the diseases, or confications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata shock, Dr heart fallura. List Dnly Dne Cause Dn each line. Interval Between IMMEDIATE CAUSE (Final 2 **Onset and Death** disease or condition lug reaulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE 1 YES 2 KNO DE DEATH? 1 YES 2 NO in smoth DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 X YES 2 NO 1 | Inpetiant 2 | XER/Outpetient 3 | DOA 4 ☐ Nursing Home 5 ☐ Rasidenca 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED Natural м 1 YES 2 NO ВУ investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, tactory, office 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be SMPLETED 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(a) and menner as stated. 2 XMEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end mennar as stated.

29c. LICENSE NUMBER



AND TITLE OF CERTIFIER

29b. BIGNATURE

BE

29d. DATE SIGNED (Month, Day, Year)

YEAR

9c. COUNTY OF DEATH

Baltimore

10g. CITIZEN OF WHAT COUNTRY?

14. RACE — American Indian, Black, White, etc.

White

USA

Specify.

1994

3. TIME OF GEATH

1 YES 2 XXNO

6:45P

8. BIRTHPLACE (State or Foreign

Maryland

BALTIMORE, MARYLAND 21215-0020

DIRECTOR

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Item 28 is COMPLETED

CERTIFICATION

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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

permit. Pages 1, 2, 3 should Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burta-transit and completely filled in by the funeral director, page 5 should be 24 hours after death. cremation, or HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within prior to burial, certificate has been signed by 1 h the State Dept. of Health and with t death DIRECTOR: After after hours a TO THE HOSPITAL OF THE FUNERAL DE BIED WITHIN 72 ho

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 DECEDENT'S NAME (First, Middle, Leat) 2. DATE OF DEATH MARSHAL _HAMPTON McCORD JR December 13, 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIFTH 6183 DAYS HOURS 219-10-6138 1 X M 2 | F YRS. May 19, 1925 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 2108 Eastham Road Lutherville 10e. STATE 10c. CITY, TOWN OR LOCATION Maryland Baltimore Lutherville 10e. STREET AND NUMBER 10f. ZIP CODE 2108 Eastham Road 21093 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ♥ YES 2 □ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, stc.)

1 YES NO Specify: 1 Never Married 2 Merried 3 Widowed 4 Divorced WII 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INQUSTRY (Specify only high Elementery/Secondery (0-12) College (1-4 or 5+) Engineer Steel 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Marshal Hampton McCord Sr Dorothy Royston Briscoe 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Ricketts Leisure Dt. Ellicott City Maryland 21043 20e, METHOO OF DISPOSITION
1 | | Gurlar | 2 | Cremetton 3 | Removal from State
4 | Egystion 8 | Other Scrape 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - Cify or Town, State competery, crematory of other place)
Dulaney Valley Memorial Gardens 12/17 floatellon 8 - Other (Specify) Lutherville, Maryland 21. SUCHATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212 23. PART I. Enter the diseas Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition CUTE MYOCARDIAL FNFARCTION reaulting in death) ORONARY Sequentially list conditions, If any, leading to immediate xpertensive Atherosclerotic Cardiovascular Disease cause. Entar UNDERLYING CAUSE (Disesse or Injury that Initiated eventa

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ascular DISEUSP

DUE TO (OR AS A CONSEQUENCE OF):

24a. WAS AN AUTOPSY 1 TES TO NO

8 Other (Specify)

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO

Interval Between

Onset and Desth

MINUTES

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL

		DE OF OFFICE (Spinor)	orny ornoj
1 YES 2 NO	HOSPITAL: 1 Inpetient 2 ER/Outpatient 3	DOA 4 Nu	R: Irsing Home 5 Reelden
27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME OF	28c. INJURY AT
1 Natural 5 Pending	(Month, Day, Year)	M	WORK?

28e. PLACE OF INJURY — At home, ferm, street, 1ectory, office building, stc. (Specify) 3 Sulcide 8 Could not be 4 Homicide

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

12/14/94

28d. DESCRIBE HOW INJURY OCCURED

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) end manner es stated. 2 MEDICAL EXAMINER end/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(e) end manner as stated.

296. SIGNATURE AND TITLE OF 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year)

D-34124

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADDRESS O

> 7600 Osler Drive Towson, Maryland 21204 Milto Suite 213

M

32. BEGISTRAN'S SIGNATURE PARCELL

(Check only one)

resulting In death) LAST

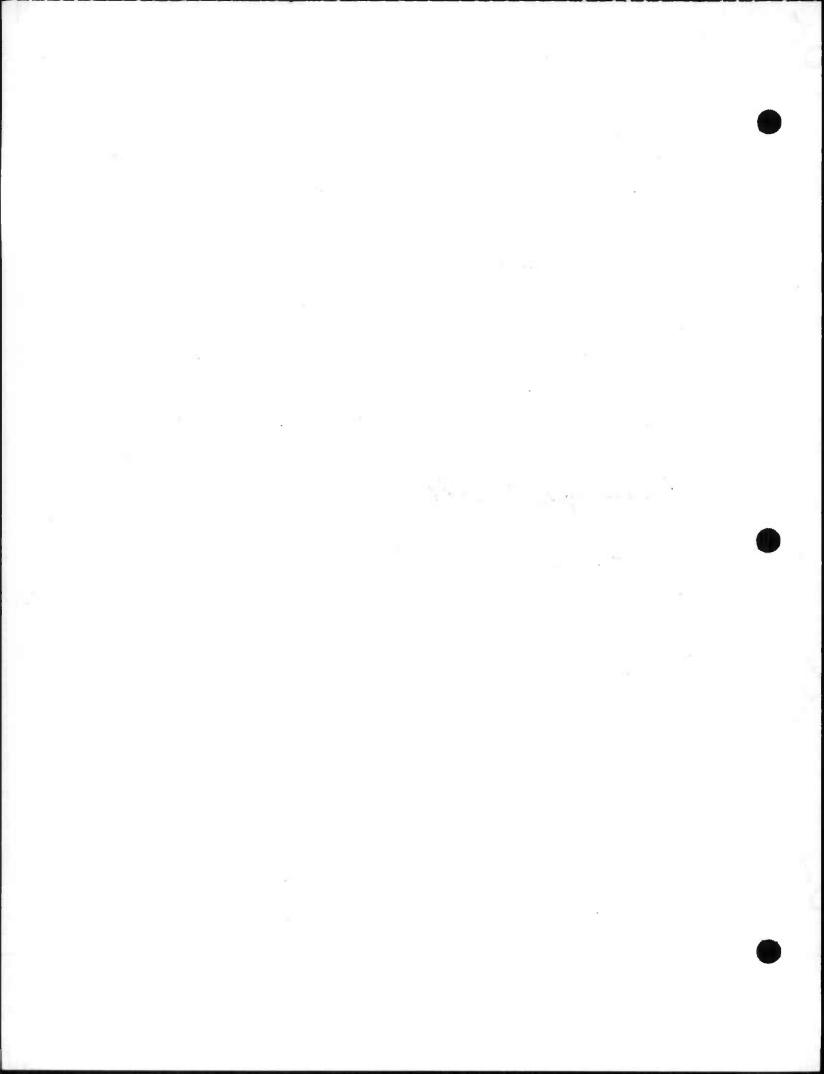
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 3. TIME OF DEATH												
	1. DECEDENT'S NAME (First, Middle, Last)	irst, Middle, Last) 2. DATE OF DEATH										
	GEORGE	ARTHUR		MAYNES	S JR.		2,1994	YEAR	11:14P	М		
				UNDER 1 YEAR	UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) April 23, 1		BIRTHP	LACE (State or Foreig	in .		
	217-24-7206 9a. FACILITY NAME (If not institution, give stre	1 M 2 □ F 65	YRS.		OCATION OF D	land						
DIRECTOR	St Joseph Hospita	22.55311 67										
EC	10a. STATE 10b. COUNTY		10c. CITY, 7	OWN OR LOCATION					10d. INSIDE CITY			
	Maryland Bal	timore	To	wson					LIMITS?			
FUNERAL	1522 Putty Hi	ll Avenue		101. ZIF	286		USA		AT COUNTRY?			
5	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U	J.S. ARMED			NC ORIGIN? (Specify Ye		, RACE	- American Indian,			
ВУ	1 Never Merried 2 Married 3 Widowed 4 Divorced	FORCES? 1XX YES IF YES, GIVE WAR OR DAT KOYE	2 □NO ES d	If yea, specify		n, Puarto Rican, atc.)		Specify	White White			
COMPLETED	15. DECEOENT'S EDUCA (Specify only highest grade co	TION (mpleted)	(Give kind of work life. Do NOT use re	done during most of	working	16b. KIND OF BU	SINESS/INDUS	STRY				
PLE	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Sales	Hired.)		Printi	na					
OM	17. FATHER'S NAME (First, Middle, Last)		ou1c5	18	. MOTHER'S NA	ME (First, Middle, Maiden						
BE C	George Arthur Mayne	es			Regir	na Johanna Du	mler					
0	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tox		ode)	· · · · · · · · · · · · · · · · · · ·			
-	David P. Maynes					Maryland 21						
	20a. METHOD OF DISPOSITION 1 Weurisi 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens 12/15 Lutherville, Maryland											
	22. NAME AND ADDRESS OF FACILITY											
	Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212											
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ahock, or heart failure. List only one cause on each line. Approximate interval Between											
	IMMEDIATE CAUSE (Final											
	resulting in death)								2yes.			
	OURT TO (OR AS A COMSEQUENCE OF):											
ō	Sequentially list conditions, if any, leading to immediate											
CAT	cause. Entar UNDERLYING											
CERTIFICATION	CAUSE (Disease or Injury that initiated eventa treauting in death) LAST											
HH	reaulting in death) LAST											
AL	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY DEDECEMBERS									NGS		
200	Destate Mallita PERFORMED?								MAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH?	BE		
ME												
AN.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
PHYSICIAN: MEDIC		HOSPITAL: OTHER:										
HYS	27. MANNER OF DEATH	28a, DATE OF INJURY	28b. TIME O			6 Other (Specify)	INJURY OCCUI	RED		\dashv		
	1 Natural 5 Pending	288. DATE OF INJURY (Morith, Day, Year) 289. TIME OF INJURY AT WORK? M 1 Tyes 2 No										
ED BY	2 Accident Investigation 3 Suicide 6 Could not be datarminad datarminad 4 Homicide Homicide Homicide Accident Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28b. PLACE OF INJURY — At home, farm, street, factory, office City or Fown, State)											
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COMPLETED	(Check only	AN: To the best of my knowled On the basis of axamination a							and manner as state	d.		
	296, SKINAPUNE AND TITLE OF CERTIFIED				. LICENSE NUN				Month, Day, Year)	-		
O BE									13, 1994			
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
ŀ	Charles B. 31. DATE FILED (Month, Day, Year)	HATTON 32_REGISTRAR'S SIGNAT	<u>/600 Osler</u>	Drive Tows	on, Mary	land 21204	Suite	411				
	DEC1 5 1994 Jul	32 REGISTRAR'S SIGNAT	M									





FOR STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH YEAR MARY CAROLINE MACKIN DEC 1994 Р 13 8:00 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Dev. Year IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign HOURS 1 M 2 X F YRS. 214-30-3540 96 September 13,1898 Maryland Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR Presidential Woods Health Care Center Adelphi Prince George's RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWH OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Prince George's Bowie permit, 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1111 Port Echo Lane signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit Health and Mental Hygiene prior to burial, cremation, or removal. 20716 United States Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 💢 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—
If yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 YES 2 NO Specify: BY Specify 3 X Widowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION ETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 18b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL 10 Homemaker once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Frederick Eikenberg Margaret Hack BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Mrs. Mary M. Goldbeck 1118 Port Echo Lane Bowie, Maryland 20716 be 20e. METHOD OF DISPOSITION
1 № Burlal 2 □ Cremetion 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State must Donation 5 - Other (Specify) Most Holy Redeemer Cemetery 12/16/94 Baltimore, Maryland examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna 22. NAME AND ADDRESS OF FACILITY Marle T. Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, 21214 medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurs. List only one cause on each line intarvai Between IMMEDIATE CAUSE (Fins) Onsat and Death the disesse or condition reaulting in dasth) . Pneumonia 2 Wks event, OUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Seausntisily list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, Isading to immediats cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated syents resulting in dasth) LAST 6 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MEDICAL 24a. WAS AN AUTOPSY PERFORMED? Alzheimers Disease 1 TYES 2 X NO 1 | YES 2 | NO has been s Dept. of H PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square HOSPITAL OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate h HOSPITAL: OTHER:
4 X Nursing Home 5 - Realdence 8 - Other (Specify) 1 YES 2 XNO Inpetient 2 - ER/Oulpetient 0 27. MANNER OF DEATH 28a, DATE OF INJURY 28c. INJURY AT 28b. TIME OF 28d, DESCRIBE HOW INJURY OCCURED marked, 1X Natural 1 YES 2 NO BY After death Investigation 2 Accident Sulcide 26s. PLACE OF INJURY — At home, lerm, street, lectory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 🗌 28 is DIRECTOR: A COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER 1X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated, (Check only one) TO THE FUNERAL IDERAL IDER MITHIN 72 H 2 __ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year BE Dec. 14, 1994 2 30. NAME AND ADDRESS OF COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M.D. De Vore, Paul Α. 4203 Queensbury Rd, Hyattsville, MD 20781-1435 32 ESTRATA SIGNATURE CANALLY DHMH-16 Rev 1/69

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

_	REGISTRAN				CALE	OF	DEALL	1	REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	NHOL		MIKULSKI JR. 2. DATE OF DEATH MONTH DOO 1/2 1994			4YEAR	3. TIME OF DEATH 9:18 pm				
	4. SOCIAL SECURITY NUMBER 199-12-0832	5, SEX 6	AGE (In yrs. les	t birthday)	IF UNDER 1	YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF (Month, D	ay, Ybar)	8. BIRTHPLACE (State or Fo)
N.	9a. FACILITY NAME (If not institution, give st Saint Joseph Med				9b. CITY, 1	D. CITY, TOWN OR LOCATION OF DEATH TOWBON, Maryland 11 /09 /1924 PA 9c. COUNTY OF DE. Baltir						ATN
Ĕ	RESIDENCE OF DECEDENT											
DIRECTOR	MD.				r, town on Balti					10d. INSIDE CITY LIMITS? 1 ¬-YES 2 □ NO		
ا بر	10e. STREET AND NUMBER				101. ZIP CODE 10g. CITIZEN OF						ZEN OF W	
FUNERAL	3406 Northway Dri						21234			U	SA	THAT GOUNTANT
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT I FORCES? 1 D IF YES, GIVE WAS 1945-1948	YES 2 D		14	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 NO Specify: 12. WAS DECEMBER, White, all Specify: Wh						
	15. DECEDENT'S EDUC		16a. DE	CEDENT'S	USUAL OCC	CUPATIO	ON	18b. KII	ND OF BUS	SINESS/IND	DUSTRY	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT us	rork done du e retired.) arsha		st of working					
≥	17. FATNER'S NAME (First, Middle, Last)			20 110	22 0110							
BE CO		H John	M	ikuls	ski S	r.	Anna Anna	AME (First, Midd	fle, Maiden	Surname)	5	Stegora
0	190. INFORMANT'S NAME (Type/Print) George J. Mikulsk	i III.					nd Number or Rural Drive					
	20e. METNOD OF DISPOSITION 1		20b. PLACE /	AND DATE O	F DISPOSIT		me of	DATE	20c. LO	CATION —	City or Tox	
			Parkw	ood (Cemet	ery		12 - 17	Ba1	timo	re Mo	i.
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE					J. Webe		eral	Home		
	Tulles	Well					. Cheste				o Ma	21231
											Interval Batwean Onset end Daath	
CERTIFICATION	Sequantielly liet conditions, It any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST											
8		3				-						
EDICAL	PERFORMED?								WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO COMPLETION DF CAUSE			
Σ	1 YES 2 NO DF DEATH? 1 YES 2 NO											
Z	DE UNE CASE DEFENDED TO COMPANY											
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:											
2	1 - YES 2 - YO	1 Inpatient 2 🗆 E		□ DOA			e 5 🗌 Rasidenca	8 Other (S)	pecify)			
BY PHYSICIAN:	27. MANNER OF DEATN 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? INJURY AT WORK? WORK?										
2	3 Suicide 8 Could not be determined	treet, factor	y, offic		281. LOCATIO City or To	ON (Street e bwn, State)	and Number	or Rural A	oute Number,			
COMPLE	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, end due to the best of my knowledge, death occurred at the time, date and place, end due to the best of my knowledge, death occurred at the time, date and place, end due to the best of my knowledge, death occurred at the time, date and place, end due											10 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -
3				vearigation	, my opi		THE DESIGNATION OF THE	. inne, trata enc	piaca, an	uua io th	m CAUSO(S)	and manner as stated.
H H	296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NU D30263	MBER		29d. DAT		(Month, Day, Year) 2-94		
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) FRANCIS KHOO, M.D., ST. JOSEPH MEDICAL CENTER, 7820 YORK RD., TOWSON, MD. 21204											
The second	31. DATE CLEO (Aronth, Day, Year) 1994	32. REGISTRAR	S SIGNATURE	ll.								

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FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CI	<u>:KIIF</u>	ICALE	: OF	DEATH		REG. NO.				
1	1. DECEDENT'S NAME (First, Middle, Last)	_						2. DATE OF		AY.	YEAR	3. TIME OF DEATH	
	Frank	J.	Mazzone			-		12-	1	4 -	-94	11:15	A.M
	4. SOCIAL SECURITY NUMBER	5. SEX		AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year)					my Manel		Count	IPLACE (State or Fore	
- 1	293-01-0723	1 M 2 □ F 85 YRS. MONTHS DAYS MOURS MIN. July 9, 1							9,1	909	Mass	Sachuset	tts
	9e. FACILITY NAME (If not institution, give st				9b. CITY,	TOWN C	OR LOCATION OF D	EATH		9c. COU	NTY OF D	EATH	
OR	8803 Wilson A	vunue								Bal	time	ore	
5	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY									1242			
DIRECTOR				10c. CITY, TOWN OR LOCATION							10d, INSIDE CITY LIMITS?		
	Maryland 100. STREET AND NUMBER			Ва	ltir					YES 2 NO			10
FUNERAL				101. ZIP CODE						_		WHAT COUNTRY?	
W	3515 E. Baltim				21224						A.		
5	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	X YES 2 N	MED IO							14. RACE Black	E — American Indian k, White, atc.	,
A	3 ☑ Widowed 4 □ Divorced	IF YES, GIVE W	AR OR DATES				2 NO Specif					"White	
	15. DECEDENT'S EDUC		WII	OFBRUTIO				1000					
COMPLETED	(Specify only highest grade	completed)	/G	ve kind of v Do NOT us	vork done d	during mo	on st of working	18b. Kt	ND OF BUS	SINESS/INE	DUSTRY		
2	Elementery/Secondary (0-12) 8th	College (1-4 or 5 +	-)	50 1101 03		of.	itter	De	4h1.	- h - m	C.L.	1 C	
Ž I	17. FATHER'S NAME (First, Middle, Last)				PIL	Jer.					St	eel Com	p.
							18. MOTHER'S NA	ME (First, Midd	lle, Maiden	Sumame)			
B	Michael 190. INFORMANT'S NAME (Type/Print)	Mazzo					L						
임							nd Number or Rural						
1					_	-	Avenue						
	20g. METHOD OF DISPOSITION 1-X Burlel 2 Cremation 3 Ramo	oval trom State	20b. PLACE A cemetery, cre	ND DATE (net <u>or</u> y or o <u>f</u>	per place)	TION /Na	me of	DATE		CATION -			- 1
	4 Donetion 5 Other (Specify)		HOTA	Rec			Cemeter		Bal	timo	re,	Maryla	nd
	ST. SIGNATURE OF BREHAL SERVICE LICE	ENSEE //					D ADDRESS OF FA		о т	- Ti		al Home	
- 1	· Cearly	100	uns		26	53 5	Conk	ling	S+	Pal	ter	Md.212	l
	23. PART I. Enter the dispasse, or co	omplications that	ceused the de	eth. Do n	ot enter	the mo	de of dying, suc	h es cerdiec	or respl	ratory an	reat,	Approximat	
	23. PART I. Enter the disparation of the course on each line. IMMEDIATE CAUSE (Final) Approximate interval Between Onset and Death												
	disease or condition										Onset and t	Duali	
ŀ	resulting in death) DUE TO (eq AS A CONSEQUENCE OF):											\dashv	
ا ج	LIPLUR IV ZA										j	- 1	
0	Sequentially list conditions,										<u> </u>		
YA!	ceuse. Enter UNDERLYING												
Ĕ	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
F	resulting in death) LAST		AA	900	(1/								
2												1	
EDICAL CERTIFICATION	PART II. Other algnificent conditions	contributing to	deeth but not n	sulting I	n the uno	derlying	cause given in	Part I. 24	PERFORMED? 24			. WERE AUTOPSY FINE AVAILABLE PRIOR TO	
8								1	YES 2	NO NO		COMPLETION OF CALL OF DEATH?	USE
¥	OF BEATER										1 YES 2 NO		
ä	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEA	TH YE	SIN	10 L	UNCERTAIL	N 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOGBITAL	26. PLAC	E OF DEAT	H (Check o	<u> </u>							
Si I	1 TES 2 NO	HOSPITAL: 1 Inpetiant 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)											
£	27. MANNER OF DEATH	28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCC							CURED				
84 F	1 Natural 5 Pending	(IMONII, De	sy, reary	mai	M		RK? 'ES 2 NO						
- 10	2 Accident 3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, tarm, street, factory, office 28f. LOCATION (Street								N (Street a	nd Number	or Rural R	loute Number,	
COMPLETED	4 Homicide determined	bunding,	atc. (Specify)					City or 16	own, State)				ì
וש	29m. CERTIFIER 1 CERTIFYING PHYSIC	TAN: To the heat of	em knowtodno do	th	d =0.0b = 01=								
ğ	(Check only one) 2 MEDICAL EXAMINER												. 1
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296. LICENSE NUMBER 29d. DATE SIGNE										(Month, Day, Year)			
2	Jose Hernande	z M.D.	- (D 201	.70			LZ-1	.5-94	
	30. NAME AND ADDRESS OF PERSON WHO												
	Jose Hernande	V		sler	Dr	• B	altimo:	e Md	. 21	204			
	DEC1 5 1994	REGISTRAL	R'S SIGNATURE										
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Item4 ITEMS:

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	LENWORTH V. MORGAN DEC. 9 94 1										3. TIME OF DEATH 1727 P M		
	4. SOCIAL SECURITY NUMBER 213-63-0622	5. SEX	8. AGE (in yrs. las	st birthday) YRS.	MONTHS DAVE MOURE MAN (Month, Day Year)							a. BIRTH	IPLACE (State or Foreign
OR	9a. FACILITY NAME (If not institution, give sti 417 EDSDALE ROA				96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY							INTY OF D	EATH
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c CI3	Y, TOWN								10d. INSIDE CITY
DIRECTOR	Md				1 to	on Econ							LIMITS?
	10e. STREET AND NUMBER] Du	1 00	101	ZIP COD	E			IZEN OF V	VHAT COUNTRY?	
ER/	417 Edsdale Roa	ıd					2122	29					
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	☐ YES 2 ☐ I			WAS DEC	ENDENT C	F NISPAN	n, Puerto R	? (Specify Yes lican, atc.)		S A 14. RACE Black Speci	American Indian, k, Whita, alc.
	15. DECEDENT'S EDUC	ATION	18a, DE	CEDENT'S	USUAL O	CCUPATIO	IM.		185	KIND OF BU	DIMEGO (IM	DUCTOV	DIACK
COMPLETED	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5 +	(G life	Unkn	work done se retired.)	during mo:	st of workin	ng	100.	KIND OF BO	31NE33/114	DOSTRI	
O	17. FATNER'S NAME (First, Middle, Last)						18. MOTI	NER'S NA	ME (First, M	tiddle, Malden	Surname)		
ш	William L. Morgan						My	yrt1	e B.	Dowes			
TO B	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	S (Street a				er, City or Tow	n, State, Zi	p Code)	
	Myrtle Morhan			4123	Ron	is Ro	ad	Balt	to, M	ld 212	80		
	20g. METNOD OF DISPOSITION 1 \(\text{Disposition} \) Burial 2 \(\text{Cremation} \) Cremation 3 \(\text{Remo} \) Remo	wal from State	20b. PLACE cometery, cre	AND DATE	of DISPOS	SITION (Na			DATE	20c. LO	cation –	City or To	wn, Stata
	1 N Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1 Signature of Funeral Service Licenses 22. NAME AND ADDRESS OF FACILITY												r, Ma
	Duni	26.	Len	tt	100					ue Ba	lto.	Md 2	1215
	23. PART II. Enter the diseases, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) BUE TO (OR AS A CONSEQUENCE OF):									Approximate Interval Between Onset and Death			
ICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Pleases or Injury.												
ERTIF	CAUSE (Disease or Injury that initiated events resulting in death) LAST d.												
MEDICAL CERTIFICATION	PERFORMED? ANA COM OF I										WERE AUTOPSY PINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
	DID TOBACCO USE CONTR	IBUTE TO CA	USE OF DEA	TH Y	ES 🗆	NO 🗆	UNC	ERTAIN	N 🗆				
BY PHYSICIAN:		HOSPITAL:		E OF DEA	OTHE	R:	3237						
H H	27. MANNER OF DEATN		□ InpetIent 2 □ ER/OutpetIent 3 □ DOA 4 □ Nursing Home 5 X SeeIdence 8 □ Other (Specify) 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW							1-2	N. ILIBY OC	CUBED	
7	1 Natural 5 Pending	(Month, De	ly, Year)	IN.	IURY M	WOI	RK?	NO.	200. DEG	CHIDE HOW I	NJOH! OC	CONED	
10	2 Accident Investigation 3 Suicide 8 Could not be datarmined 288. PLACE OF INJURY — A1 home, ferm, stree1, factory, office building, etc. (Specify) 288. PLACE OF INJURY — A1 home, ferm, stree1, factory, office City or Town, State)									loute Number,			
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PNYSIC X MEDICAL EXAMINER) end manner as stated.
w II	294 SIGNATURE AND TITLE OF CERTIFIER						29c. LICE	NSE NUM	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
∞	Theo dage U	Lund	ruce	5			0.	C.M.	. E				10,1994
٤	30. NAME AND ADDRESS OF PERSON WHO		E OF DEATH (ITE	М 27) (Туре		trec	·+	Ral-	timo	re l	Varv	land	1 21201
	DEC 15 1994		A CHANGE L	4	11 3	LICE	, . ,	Dar	CTIIO	10, 1	.u.r. y	Tan	2 2 2 2 7 2
	DEC 10 1004	U											

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law magnines that the death contracts the secured within 72 hours after death by the things by the attending physician and competing file for the following by the attending physician and competing filed in by the fundament of the following by the attending physician and demanded for the following the following prior to burial common or memoral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Copy of Health and Mental Hyperse prior to burial common or memoral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Copy of Health and American Prior to burial common or memoral director. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examinar must be notified at once.

1. Day, Year)

22. REGISTRAR'S SIGNATURE RANGE

31. DATE FILED (Month, Day, Year)
DEC 15 1994

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

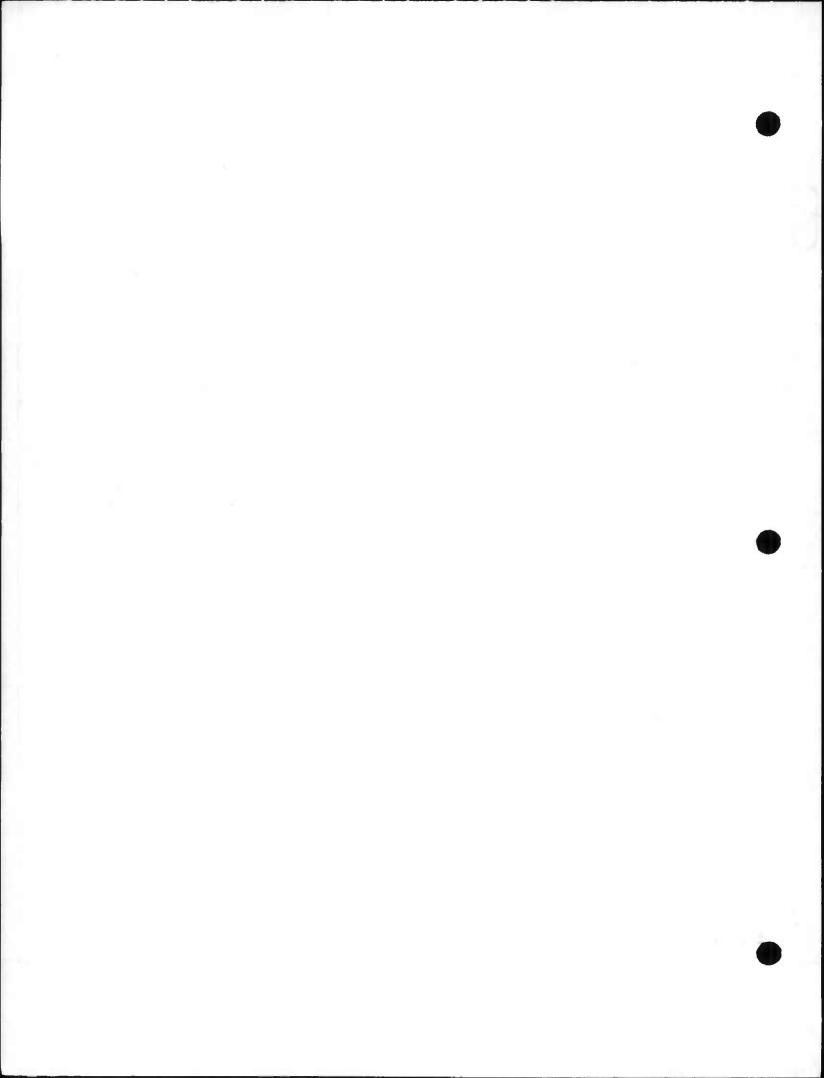
ours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	rial, cremation, or removal.	the second of the second secon
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with Jurs after death. Page 6 may be retained by the hospital or attending physician.	-	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	CONDUCTORING OF In- and in the Control of the Contr

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	1 - FOR STATE REGISTRAR	E OF MARYLAND / D CEF		OF HEALTH AND	MENTAL HYGIEN REG. NO.	_		
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF OEATH	Y YEA		E OF DEATH
	Catherine De	Court Nuge	ent.		Dec. 1	100		1:25 A
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. last bi	irthday) IF UNDER			8. B		(State or Foreign
	219-40-7685 1 D M		YRS. MONTHS	DAYS HOURS MIN.	November 28,	1916 Ph	ilippir	nes
	9s. FACILITY NAME (If not institution, give street and n	umber)	9b. CITY,	TOWN OR LOCATION OF		9c. COUNTY		
6	Stella Maris Hospice			Towson		Baltir	nore	
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		10c. CITY, TOWN O	B LOCATION				
<u>=</u>			_				Li	ISIDE CITY
	Maryland Baltimo	ine	OWS	10f. ZIP CODE		10g. CITIZEN		res 2 XX NO
FUNERAL								DUNTRY?
N N	816 Mockingbird Lane	DECEDENT EVER IN U.S. ARME	in 12 1	21204	ANIC ORIGIN? (Specify Yea		SA	
	1 Never Married 2 Married FOR	CES? 1 YY YES 2 NO	1	yes, specify Cuban, Maxi	icen, Puerto Ricen, etc.)			erican Indian, , atc.
BY	3 Widowed 4 Divorced	WII	'	TES 2 XXNO Spe	cify:		Specify:	White
ED	15. DECEDENT'S EDUCATION	16a. DECE	DENT'S USUAL OC		16b. KINO OF BUS	INESS/INDUSTI	RY	781100
Щ	(Specify only highest grade completed Elementary/Secondary (0-12) College	(Give life, Do	kind of work done of NOT use retired.)	luring most of working				
A P	54	_ N	urse		Army			
COMPLET	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S	NAME (First, Middle, Maiden	Sumame)		
BE (Julian DeCourt			Alr	na Lloyd			
TO B	19a. INFORMANT'S NAME (Type/Print)	19b. A	MAILING ADDRESS	(Street and Number or Run	al Route Number, City or Town	, State, Zip Code	2	
F	Margaret Nucent	8	04 Powers	Street Baltin	more, Maryland	21211	21218	
	204, METHOD OF DISPOSITION 1 XBurial 2 Cremetion 3 Removal from	20b. PLACE AND	D DATE OF DISPOSI	TION /Name of	DATE 20c. LOC	CATION - City		
	4 Denation 5 Other (Specify)	Arlingt	ion Nation	al Cemetery	12/19 Arli	ngton, V	irginia	3
	21. SIGNATURE OF FUNERAL SERVICE ACCENSES	1	22. 1	AME AND ADDRESS OF	Mitchell-Wiede	fold Home	2	
	1 mns / loxa	RPMAK		6500 York	Road Baltimon	Maryl.	and 212	212
	23. PART I. Enter the diseases or complica	tions that caused the death	h. Do not antar					Approximata
	ahock, or heart fallure. List only iMMEDIATE CAUSE (Final	One cause on each ilne				,,	- 6	ntarval Between
	disease or condition	Longsill	we h	sect for	/ova			Miser and Death
	reaulting in dasth)	DUE TO (OR AS A CONSEQUE	ENCE OF):	,				
z		Arter	os dere	seis			j	
ERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUE	ENCE OF):					
S	Cause. Enter UNDERLYING CAUSE (Disease or Injury							
브	that initiated events	DUE TO (OR AS A CONSEQUE	ENCE OF):					
ER	resulting in death) LAST							
LC	PART II. Other algorificant conditions contrit	outing to death but not rear	ulting in the un	deriving causa givan i	in Part I. 24a, WAS AN	AUTOPSY	24h, WERE	AUTOPSY FINDINGS
MEDICAL					PERFOR	MED7	AWAILA	BLE PRIOR TO ETION OF CAUSE
ED	Record stretes	0/4 /1	efuel.	KI his	1 □ YES 2	□ NO	OF DEA	ITH?
Σ.						- 1	473.4	ES 2 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINERY? 1 YES 2 YHO 1 Ingellent 2 ERPONIPATION DOA A Novembre 5 Residence 6 Other (Tipocify) 27. MANNER OF DEATH 28st. DATE OF HUJURY 28st. NUMBER OF DEATH DOS (Number								
SIC	EXAMINENT 1 YES 2 YNO 1 Input		DOA 4 SONITE	1	and the second s			
Η		DATE OF INJURY 2	-	ing Home 5 - Residence 29c. INJUNY AT	294. DESCRIBE HOW IN	LIURY OCCUBE	n.	
	1 Natural 5 Pending	(Morth Day, Year)	MURY	WORK?	- Contraction - Contraction			
ЭВУ		PLACE OF INJUSTY - At home.	. farm, street, facto	100 miles 10000 1000 11	28f. LOCATION (Street a	nd Number or Ru	rist Roote No	mber
TED	4 Homicide distermined	hullding etc. Specific			City or Town, State)			
COMPLET	29a. CERTIFIER 1 SCENTIFYING PHYSICIAN: To I	the bear of officerations of the	adament at the co				_	
MP	(Check only and MEDICAL EXAMINER: On the						main and -	annes en merce
	29b. SIGNATURE AND TITLE OF CERTIFIER							
BE	THE ST SENIER			29c. LIDEPASE N		29st. DATE BIG	NED (Month,	Day Year)

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL BECORDS P.O.

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEPARTM CERTIFIC			MENTAL HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATN
		Joan Victor				December 1		194 230 PM
			100	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTN (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
	578 44 7744 9a. FACILITY NAME (If not institution, give stre		y YRS.	964 (10.5)		Oct.25,19		New York
œ	3022 New York A	The second second			R LOCATION OF DE	EATN		TY OF DEATH
DIRECTOR	RESIDENCE OF DECEDENT	venue		Baltimo	ore		Balt	timore Co.
	10a. STATE 10b. COUNTY			OWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?
	Maryland Balt	timore	Ba1	timore				1 TES 2 NO
RA	3022 New York Av	tonllo		101.	ZIP CODE			EN OF WHAT COUNTRY?
FUNERAL		12. WAS DECEDENT EVER IN		13. WAS DEC	21227 ENDENT OF HISPAN	IIC ORIGIN? (Specify Yea		S.A.
	1 Never Married 2 Married	FORCES? 1 YES		It yes, spe		n, Puerto Rican, etc.)		Black, White, atc. Specify:
D BY	3 Wildowed 4 Divorced			<u> </u>				White
	15. DECEDENT'S EDUCA (Specify only highest grade oc	ompleted)	(Give kind of work life. Do NOT use re	done during mos	N st of working	166. KINO OF BUS	INESS/INDUS	STRY
2	Elementary/Secondary (0-12)	College (1-4 or 5+)	Housewit			Home N	Malrox	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTNER'S NA	ME (First, Middle, Meiden		
BE C	Jo	seph John P	rock		F1c	orence Mart	tha Am	abrose
01	19a. INFORMANT'S NAME (Type/Print)				nd Number or Rural I	Route Number, City or Tow	n, State, Zip C	Code)
_	Donald Hott		1583 E1			Severn, M		
ĺ	20a. METHOD OF DISPOSITION 1 № Burlal 2 □ Cremation 3 □ Ramov	ral from Stata come	PLACE AND DATE OF D etery, cremetory or other	niecei				ty or Town, State
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICES	NSEE G	Len Haven	Memori 22. NAME AN	al Park D ADORESS OF FA	12/15 G16	n Bur	nie, Maryland
ŀ	· secome	Francis	who			ce Funeral		
	23. PART i, Enter the diseases, or co	mplications that ceused	the deeth. Do not	enter the mo	de of dying, auc	Hwy Balt h ea cerdiac or reapi	ratory arres	Md. 21225 at, Approximate
	ahock, or heart fallura. LI iMMEDIATE CAUSE (Final	st Dnly Dna cause Dn ea	ich lina.					Interval Batween Onset and Beath
	disease or condition resulting in death) a. \(\text{Ver} \) \(\text{Cullive} \)							2 whs
		/	CONSEQUENCE OF):	·				2 =
NO N	Sequentially list conditions, b.	DUE-TO (OR AS A	CONSEQUENCE OF:	ases				ais yrs.
EA	If any, leading to immediate cause. Enter UNDERLYING	Colon	Conce	1				4yre
Ĕ	CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A	CONSEQUENCE OF):					1/
CERTIFICATION	resulting in deeth) LAST							
AL C	PART II. Other algnificant conditions	contributing to deeth be	at not reculting in the	ne underlying	ceuse given in	Part I. 24e. WAS AN		24b. WERE AUTOPSY FINDINGS
EDIC						PERFOR	V	AWAILABLE PRIOR TO COMPLETION OF CAUSE
¥ I							7	OF DEATH?
ÿ	DID TOBACCO USE C	ONTRIBUTE TO	CAUSE OF D	EATH Y	ES NC) A		
PHYSICIAN: M		HOSPITAL:	0	26. PL THER;	ACE OF DEATH (Ch	eck only one)		
14S	1 YES 2 NO	1 ☐ Inpatient 2 ☐ ER/Output 26a. DATE OF INJURY	itlant 3 DOA 4	Nursing Nom-		6 Other (Specify)		
	1 Natural 5 Pending	(Month, Day, Year)	26b. TIME OF	M 1 Y	RK?	26d. DESCRIBE HOW II	NJURY OCCU	RED
2 Accident investigation 28e DI ACE DE IN HIGH. At home ferry short feature of the							and Number or	r Rural Routa Number,
3 Suicide 4 Nomicide 4 Nomicide 5 Could not be detarmined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, dasth occured at the time, data and place, and due to the cause(a)								
								1.
- 11	296. SIGNATURE AND TITLE OF CERTURIER	1011			29c. LICENSE NUM	MBER	29d. DATE !	SIGNED (Month, Day, Year)
TO BE	Win C Wa	leepend of	19		124	356	1	2/14/94
-	30. NAME AND ADDRESS OF PERSON WNO William C. Wafe			Has pi	fal la	Balt. M	ind.	21229
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	TURE/ /	9 -7 -				
	DEC1 5 1994 Jul	is divideor Rand	all					



YEAR 1994 3. TIME OF DEATH

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

Approximata Interval Between Onset and Death

2. DATE OF DEATH MONTH

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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6876	pacitive that the death certificate he executed within 28 h
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B	relificati
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Ö	se tha
HE WE	raction
A	The law
OF VITAL RECORDS, P.O. BOX 68760,	SEDITAL OF ATTENDING DAYSICIAN. The
DIVISION OF	ATTEMPING
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	CDITA

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				Margare	t Anna	a Pappa	as				ecem	ber	11, 1	994	
			4. SOCIAL SECURITY NUMBER	5. SEX 8.	. AGE (In yrs. I		F UNDER 1		IF UNDER 24	HRS. 7.	DATE OF E	BIRTH		8. BIRTHE	PLACE (State or Foreign
	_		218 10 8605	1 □ M 2 📉 F	75	YRS.	ONTHS	DAYS	HOURS		eb. 2		919		vland
	should	ì	9a. FACILITY NAME (If not institution, give	street and number)		1	b. CITY,	TOWN OR	LOCATION	OF DEATH		-,		NTY OF DE	
	ന	<u>۳</u>	Harbor Hospita	al Center			Ba1t	imo	re				===	====	==
	1, 2,	DIRECTOR	RESIDENCE OF DECEDENT							-					
	Pages	Ä	10a, STATE 10b, COUNT	TY		10c. CITY,	TOWN OF	LOCATIO	ON						10d. INSIDE CITY LIMITS?
	.e.	ā	Maryland Ann	ne Arundel		Ba1	timo	re							1 YES 2 NO
	permit.	RAL	10e. STREET AND NUMBER					101. 2	ZIP CODE				10g. CiTi	ZEN OF W	HAT COUNTRY?
e.	JS.f.	IER.	205 West 5th Av	<i>J</i> enue					2122	25			U	.S.A	•
020 physician	ial-tr	FUNE	11. MARITAL STATUS	12. WAS DECEDENT E FORCES? 1						HISPANIC (or No-	14. RACE	- American Indian, White, atc.
		ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	IF YES, GIVE WAR		JNO			NO	Mexican, P Specify:	uarto Ricar	1, etc.)		Specify	
215-0	as the	0 8	3 g wildowed 4 Divorced												White
	use a	ші	15. DECEDENT'S EDI (Specify only highest grad		16a. E	Give kind of wor	SUAL OC	CUPATION	of working		16b. KIN	D OF BUS	SINESS/INC	USTRY	
27	for 1	E	Elementary/Secondary (0-12)	College (1-4 or 5+)	"	fe. Do NOT use	retired.)								
AND 21	ched	COMPL	12th		H	lousewi	fe				Ho	ome M	ı́aker		
Je h	detach once.	Ş.	17. FATHER'S NAME (First, Middle, Last)			_			18. MOTHE	R'S NAME	(First, Middl	e, Maiden	Sumame)		
<u> </u>	2 %	ш	٠	Joseph Ande	erson					Anna	Bec	ker			
MARY retained by	5 should notified	9	19a. INFORMANT'S NAME (Type/Print)		1	19b. MAILING A	DDRESS	Street and	Number or	r Rurel Rout	e Number, (City or Town	n, State, Zip	Code)	
	not	2	Albert Andersor	1	5	West	11tl	a Av	enue]	Balti	more	, Ma	rv1ar	nd 21225
may be	page 1 be		20a, METHOD OF DISPOSITION		20b. PLACE	E AND DATE OF	DISPOSIT	ION (Nem	eof		DATE			City or Tow	
פֿ כ	director, per must	1	15 Burial 2 Cremation 3 Ran 4 Donation 5 Other (Specify)	noval from State	HO1V	crematory or othe	r place)	etor	-x,		12/1/				Maryland
S og			21. SIGNATURE OF FUNERAL SERVICE L	CENSEE	TIOLY	A	_			OF FACILI	12/ 15	Dal	CINO	re, r	daryrand
ALIIM death. Page	tuneral di examiner		· Clerma	2		//	Geo	orge	J. 0	Gonce	Fune	eral	Home	P.A	. •
BALIIMORE, er death. Page 6 may be			guome 1	rances	neva		400	01 R	itchi	ie Hw	y.]	Balt:	imore	Md.	. 21225
S after	remove edical	- 1	23. PART I. Enter the diseases, or shock, or heart failure.	complications that c	aused tha d	death. Do no	t antar t	ha mode	a of dying	g, such a	a cardiac	or reapl	retory arr	rest,	Approximata
hours	filled in b on, or rer he medi		IMMEDIATE CAUSE (Final	List Only Ona Cause	on aach iir	va.									Onset and Dea
PZ U	the the	1	disease or condition resulting in death)	C 0	- He	and 7	علما								
within	crem	į	resoluting in death)	DUE TO (OI	R AS A CONS	EOUENCE OF):									1
executed with	con urial,	2		b. 4500											
8	to bu	RTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OI	R AS A CONS	EOUENCE OF):									
ate be C	sicia prior tra	8	cause. Enter UNDERLYING	· De De	le m	relace	-								
Tifica	the che	Ĕ	CAUSE (Disease or Injury that initiated events	DUE TO (OI	R AS A CONS	EOUENCE OF):									
, è	Hygi	F	resulting in death) LAST	4											
= =	ental ental	S													
	ind M	A	PART II. Other significant condition	ns contributing to da	ath but not	resulting in	the und	erlying	causa giv	ven In Par	t I. 24s	. WAS AN			WERE AUTOPSY FINDING
L KECOR	any	EDICAL									. 10	YES 2			COMPLETION OF CAUSE OF DEATH?
E C	of Hea	ME											-		1 YES 2 NO
Z ž	H. of	-	DID TOBACCO USE	CONTRIBUTE	TO CAL	JSE OF	DEAT	H YE	S	NO I	74				
	has be Dept.	< ∥	25. WAS CASE REFERRED TO MEDICAL	219017				_		ATH (Check					
AN- I	State	잃	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpetient 2 E	B/Outpatient		THER:			dence 8					
PHYSICIAN: The	certificate to the State	PHYSICI	27. MANNER OF OEATH	28a. DATE OF IN		28b. TIME		28c. INJUF			d. OESCRI		N.ILIBY OC	CUREO	
⊃ ₹	this with		1 Natural 5 Pending	(Month, Day,	Year)	INJUR		WOR	K?					001120	
ATTENDING		B	2 Accident Investigation	28a. PLACE OF II	NJDRY - At I	home form etc	ant factor				1 OCATIO	M (Cemat a	and Alcombine	as Donal D	oute Number,
NE OF		8	3 Suicide 8 Could not be 4 Homicide detarmined	building, ato	: (Specify)	nome, raim, att	eet, ractor	y, ornea		1	City or To	wn, State)	ina Number	OF PILITHIT PIC	oute Number,
OR AT	DIRECTOR: hours after Item 28 I	Li	20a CERTIFIER									<u>-</u>			
¥	72 =	릴	and .	BICIAN: To the best of my											
HOSPITAL	FUNERAL within 72 I	COMPL	one) 2 MEDICAL EXAMIN	ER: On the baels of axan	nination and/o	r Investigation,	In my op	inion, des	rth occured	at the time	e, data end	placa, an	d due to th	a ceuse(a)	end manner as stated.
8	d witt	П	29b. SIGNATURE AND TITLE OF CERTIFIE	ER				1:	29c. LICEN:	SE NUMBE	R		29d. DAT	E SIGNED	(Month, Day, Year)
F	TO THE FUNERA De filed within 7 IMPORTANT: 1	0	1. a. N	mano					2101	34					124
=	F 6 =		And Andrew		1				- / - /	- /			/	- 10	,

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

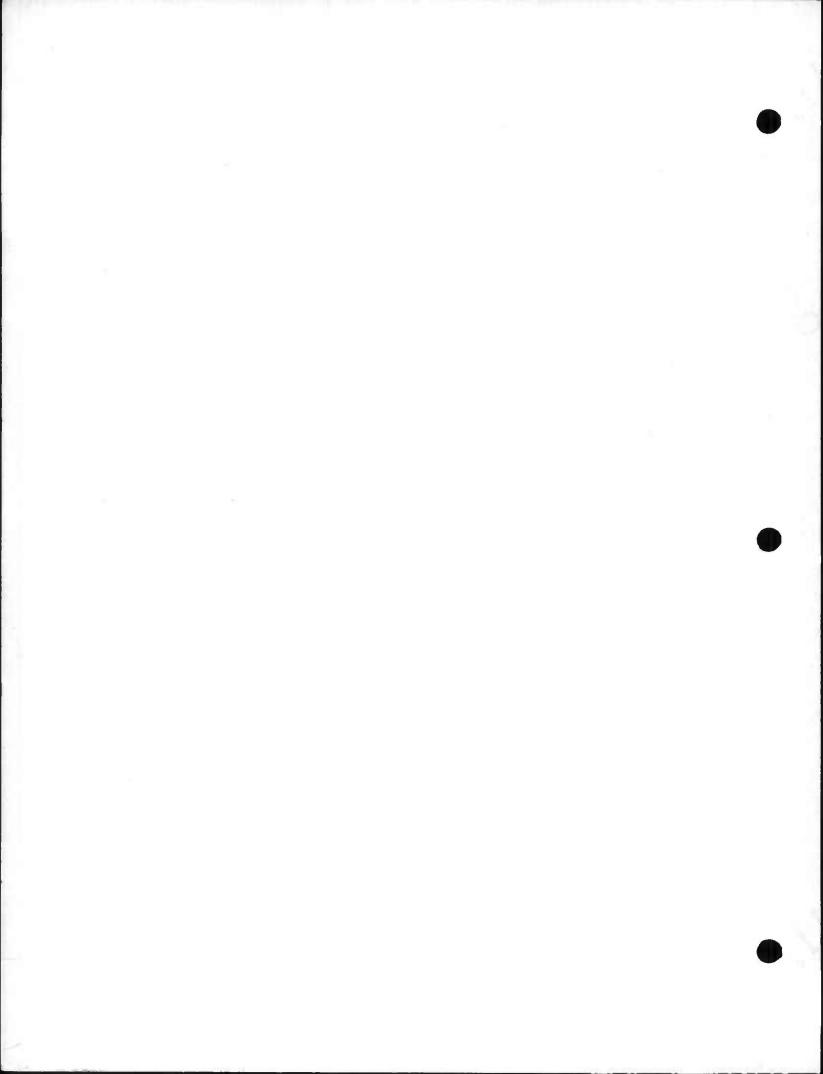
July DRUGGETRAR'S GNATURE

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31. DATE FILED (Month, Day, Year)
DEC1 5 1994

Back . Md > 1295

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**



retained by the hospital or attending physician. 5 should be detached for use as the burial-tran BALTIMORE, MARYLAND 21215-0020 BOX 68760, DIVISION OF VITAL RECORDS, P.O.

cremation.

101

evindale

32 REGISTRAR'S SIGNATURE

Pages 1, 2, 3

use as the burial-transit permit.

after death. Page 6 may be director, funeral filled in by the foundary. the completely and com executed physician death certificate be attending the atten and and signed I Health a HOSPITAL DR ATTENDING PHYSICIAN: The law this c After

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3, TIME OF OEATH VEAR Mary 920 Ha Dec 994 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER I YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 214-22-3523 1 M 2 F 91 OCT. 17, 1903 MARYLAND 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR LEVINDALE BALTIMORE RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE t TYES 2 T NO BALTIMORE FUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7206 VALLEY COUNTRY CT, APT. A-3 21208 **USA** 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No- RACE — American Indian, Black, While, stc. FORCES? 1 YES 2 1 Never Married 2 Married If yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 TYES 2 XNO Specify: BY Specify: 3 Wildowed 4 Divorced WHITE 8 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig ᆸ Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 HOUSEWIFE AT HOME 17. FATHER'S NAME (First Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) at LOUIS **BE** SILVERMAN SUSAN FOXMAN notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MR. JERRY DOLINE 7606 LORRY LANE BALTIMORE, MD 21208 pe 20 METHOD OF DISPOSITION
1 Burlet 2 Cremston 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, Stats DATE must 4 Donation 5 Other (Specify BETH TFILOH 12-12-94 BALTIMORE, MD examiner F FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 medical 23. PARY I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximete shock, Dr haart failura. List only Dne ceuse Dn eech lina. interval Between 6 IMMEDIATE CAUSE (Final Onset and Death the disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): event. other traumatic atherosclerope CERTIFICATION Cardias Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING prior CAUSE (Disease Dr injury Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 PART il. Other aignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any Lung 1 YES 2 NO OF DEATH? Shows 11/0 s certificate has been s th the State Dept. of H id, or item 23 show 1 | YES 2 | NO decisit PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 40 Nursing Homs 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY marked, 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation м 1 YES 2 NO æ 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, lactory, office building, atc. (Specify) 3 Suicide 28I. LOCATION (Street and Number or Rural Route Number, City or Yourn, State) L 8 Could not be ETED 4 Homicide 29s. CERTIFIER
(Chack not)

1 CERTIFYING PHYSICIAN: To the beet of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. TO THE HOSPITAL
TO THE FUNEFAL
Be filed within 72
IMPORTANT 2 MEDICAL EXAMINER: On the bsels of sxamination and/or investigation, in my opinion, death occurred at the time, date and piecs, and dus to the cause(e) and menner as stated. 00 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 盟 onsuelo 11 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2434 weday. w. Cenachie

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1994

3. TIME OF DEATH

10d. INSIDE CITY

1 YES 2 X NO

White

8. BIRTHPLACE (State or Foreign

Greece

USA

Specify:

14. RACE — American Indian, Black, White, atc.

1:55 A. M

BALTIMORE, MARYLAND 21215-00	urs after death. Page 6 may be retained by the hospital or attending a	in by the funeral director, page 5 should be detached for use as the removal.
	O.	filled on, o
SION OF VITAL RECORDS, P.O. BOX 68760,	TENDING PHYSICIAN: The law requires that the death certificate be executed within explorance after death. Page 6 may be retained by the hospital or attending it	OR Alter the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the intention of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Pages 1, 2, 3 should

permit.

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DIRECTOR

FUNERAL

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MEDICAL

PHYSICIAN:

BY

COMPLETED

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1 YES 2 PHO

5 Pending

6 Could not be

determined

27. MANNER OF DEATH

1 Netural

2 Accident

3 Suicide

4 Homicide

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 13 CLARA DEC. J. PAVLES 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 5/16/1898 96 HOURS 1 M 2 XF 213-74-9140 YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Lorien - Frankford N.H. Baltimore City RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Maryland Baltimore Perry Hall 10e. STREET AND NUMBER 101, ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 9001 Deviation Road 21236 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rican, etc.) IF YES, GIVE WAR OR DATES 1 YES 2 XNO Specify 3 XWidowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) Unavailable Homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John Thanos Mary Unavailable 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Kalandros 1240 Meridene Drive Baltimore, MD 20a. METHOD OF DISPOSITION
1

Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata DATE Greek Orthodox Cemetery Donation 5 Other (Specify) 12/16/94 Woodlawn, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home Kopay prusting 8521 Loch Raven Blyd. Towson, MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fallure. List only one cause on each line. **IMMEDIATE CAUSE (Final** disease or condition Dehydration resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Dementi A Sequentially ilst conditiona, DUE TO (OR AS A CONSEQUENCE OF): If sny, laading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (DR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST

myocardial Infarction GASTIOINTESTINAL Bleed DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO WUNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 | YES 2 | NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DE DEATH?

Approximate

YEATS

Onsat and Death

1 TYES 2 DING

4 Nursing Homa 5 Realdence 8 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED

1 | Inpetiant 2 | ER/Outpetlant 3 | DOA 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY M 1 YES 2 NO

28a. PLACE OF INJURY — At home, farm, street, factory, offica building, etc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, data and placa, and due to the cause(s) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

Tumerlan 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 29c. LICENSE NUMBER D39763 29d. DATE SIGNED (Month, Day, Year) 12/13/94

2117 Tannen baum 21 Crossroads MD. Drive

SA REGISTIPAR SAIGNATUR

TO THE FINE OF TO THE FINE OF

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ling physician. the burial-transit permit, Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a round after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as to	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	SICIAN: The law requires that	certificate has been signed	h the State Dept, of Health a	d, or item 23 shows an
	nat the death certi	by the attending	and Mental Hygie	ny injury, or oth
	ficate be exect	physician and	ne prior to bu	her traumati
	uted within E	completely fills	nial, cremation,	c event, the
	nours after death.	ed in by the funera	or removal.	medicai examin
(1)	Page 6 may be	I director, page		ner must be n
	etained by the hospit	should be detached		otified at once.
1	al or attend	for use as		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.							
1. DECEDENT'S NAME (First, Middle, Lest)	TINA	A. PIAS			2. DATE OF DEATH	94 * E	3. TIME OF DEATH
213-12-4973	□ M 2 🗀 F		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 10 - 3 - 189	93 N	BIRTHPLACE (State or Foreign Country) 1ARYLAND
99. FACILITY NAME (If not institution, give street STELLA MARIS HOS RESIDENCE OF DECEDENT		91	b. CITY, TOWN OF	LOCATION OF DEAT	TH	9c. COUNTY	of DEATH
10e. STATE 10b. COUNTY	TIMORE	10c. CITY, T	OWN OR LOCATIO	ЭМ			10d, INSIDE CITY LIMITS? 1 YES 2 NO
100. STREET AND NUMBER 422 WAKE ROBIN D	DRIVE			21030		10g. CITIZEN USA	OF WHAT COUNTRY?
11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	II yes, spec	NDENT OF HISPANIC lify Cuben, Mexican, NO Specify:	ORIGIN? (Specify Yee Puerto Rican, etc.)		RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12) 4 YEARS	TON inpleted) College (1-4 or 5+)	Itte. Do NOT use re	done during most etired.)	of working	16b. KIND OF BUS	SINESS/INDUST	
17. FATHER'S NAME (First, Middle, Last) ALOYSIUS HORT		HOMEMA		18. MOTHER'S NAME	E (First, Middle, Meiden PFROTE	,	
190. INFORMANT'S NAME (Type/Print) MR. LOUIS PIASE()	CKI	- 1	DRESS (Street and	d Number or Rural Roo	the Number, City or Town	n, State, Zip Code	
20a METHOD OF DISPOSITION 1 Burlel 2 Cremellon 3 Removal 4 Donetion 5 Other (Specify)	from State	PLACE AND DATE OF D	DISPOSITION (Nam	e of	DATE 20c. LO	CATION - CHY	or Town, State
Marles X. X	Carno	ki	KACZO 2525	FLEET S	FUNERAL T. BALTO). MD	21224
23. PART I. Enter the diseases, or come shock, or heart failure. List IMMEDIATE CAUSE (Finei disease or condition resulting in death)	t only one cause on ea	the death. Do not ech line.	enter the mode	e of dying, auch	na cerdiec or respi	ratory arrest,	Approximate Interval Between Onset and Dasth
Sequentielly list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A	CONSEQUENCE OF):					
thet initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE DF):					
PART II. Other algnificant conditions co	ontributing to death be	ut not rasuiting in t	ha Underlying	cauae given in Pe	24a. WAS AN. PERFOR 1 YES 2	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)							
1 YES 2 NO 1 Inpetient 2 ER/Outpetlent 3 DOA 4 Norsing Home 5 Reeldence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 1 Natural 5 Pending Natural 5 Natural							D
2 Accident Investigation 3 Suicide 8 Could not be determined Coulding, etc. (Specify) 28e. PLACE OF INJURY — At home, Ierm, street, lectory, office building, etc. (Specify) 28l. LOCATION (Street and Number or Rural Route Number, City or Town, Steet)							ural Route Number,
29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end manner ee stated. 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner ee stated.							
296. SIGNATURE AND TITLE OF CERTIFIER		- n	0	D 191	/	29d. DATE SIG	NED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEA	629 YO	RK R	1 0	OCKEYSVI	ile,	MS

BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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Item6 12-15-94 FilmG718 W.H.Per F/H STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH 6:40 15 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Dev. Year DAYS 54 HOURS YRS. G. FACILITY NAME (If not institution. 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BAYVIEW DIRECTOR MediCAL 5 RESIDENCE OF 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Ma Ba 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? tley 21229 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian Black, White, etc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puarto Rid 1 TES 2 NO Specify: IF YES, GIVE WAR OR DATES Black ВУ 3 Wildowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ry/Secondary (0-12) College (1-4 or 5 +) 10 enknown 17. FATHER'S NAME (First, Middle, Last) 18 MOTHER'S NAME (First, Middle, Maider Wers 5 40HISON BE 0 INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street 2 lar racker 5 METHOD OF DISPOSITION
Burial 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Na 127/7/9J 1 S Burial 2 Cremation 3 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL/SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Wabash Enter the disesses, of complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. 23. PART Approximata intarvai Between IMMEDIATE CAUSE (Final disease or condition Onset and Death 12200 DUE TO GOR AS A CONSEQUENCE OF resulting in dasth) CERTIFICATION Sequentially list conditiona, if any, leading to immediate OUR TO (OR AS A CONSEQUENCE OF): csuse. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE DF GEATH? 1 YES 2 NO 1 | YES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO I UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 - YES 2 -Inpatient 2 ER/Outpatient 3 DOA sing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCUREO 1 Hatural
2 Accident 5 Pending 1 YES 2 NO ВY

6 Could not be Homicide determined

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

281. LOCATION (Street and Number or Rural Route Number, City or Yown, State)

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1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner ee stated. MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time,

200. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month Day Year)

NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, 0

31. DATE FILED (Month.

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29a. CERTIFIER

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

		DEPARTMENT OF HEALTH AN						
	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF OEATH	3. TIME OF DEATH				
	Vincent Roger Strand		December 11,	1994) 7 M				
1	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. In		RS. 7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign				
	215-86-1949 1XM20F 34	YRS. MONTHS DAYS HOURS M	Month, Dey, Year) 7 - 12 - 60	Maryland				
	9e. FACILITY NAME (If not institution, give street end number)	9b. CITY, TOWN OR LOCATION (DUNTY OF DEATH				
e o	1001 N. Broadway	Baltimore		N/A				
DIRECTOR	RESIDENCE OF DECEDENT							
E	10e. STATE 10b. COUNTY	10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?				
	MD N/A	<u>Baltimore</u>		1 X YES 2 NO				
FUNERAL		101. ZIP CDDE	10g. C	ITIZEN OF WHAT COUNTRY?				
W	1001 N. Braodway 3Floor 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AI	21205		U.S.A.				
	1 Never Merried 2 Merried 1 Never Merried 2 Merried 1 FYES GIVE WAR OR DATES	ND If yee, specify Cuben, M	SPANIC ORIGIN? (Specify Yes or No- exicen, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.				
В	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES**	1 TYES 2 X NO S	Specify:	Specify: Black				
	15. DECEDENT'S EDUCATION 16a. O	ECEDENT'S USUAL OCCUPATION	18b. KIND OF BUSINESS/I					
	(Specify only highest grade completed) ((Elementery/Secondery (0-12) College (1-4 or 5 +)	Give kind of work done during most of working b. Do NOT use retired.)						
4	12ab N/A	LANDSCAPING	n/a					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		S NAME (First, Middle, Meiden Surname)				
BE C	OLIVER ROGER STRAND	Vivi	an Mounger					
9	19e, INFORMANT'S NAME (Type/Print)	b. MAILING ADDRESS (Street and Number or F		Zip Code)				
F	Vivian Dickens	520 Durham Street/	Baktimore, Mary	land 21213				
		AND DATE OF DISPOSITION (Neme of emetory or other place)	DATE 20c. LOCATION	— City or Town, State				
	4 Donation 5 Other (Specify) Green	Mount Cemetery	12/16 Baltin	nore, MD				
-	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS D MARCH FUNERA	F FACILITY					
	Demand D Johnson		th Avenue/Baltim	ore, MD 21202				
	23. PART I. Enter the diseases, or configurations that caused the dishock, or heart failure. List only one cause on each lin	eath. Do not enter the mode of dving	auch as cardiac or respiretory	arrest, Approximate				
	IMMEDIATE CAUSE (Final	в.		Interval Batween Onset and Death				
	disease or condition							
	DUE TO (DR AS A CONSEQUENCE DF):							
Z	Sequentially list conditions, Due to (DR AS ACONSEQUENCE OF): 1 Year							
Ĭ	if any, leading to immediate	OUENCE OF):						
5	CAUSE (Disease or injury	Drug USE		15 years				
Ē	that initiated events resulting in death) LAST	ODENCE OF						
CERTIFICATION	d							
AL	PART II. Other aignificant conditions contributing to death but not	reaulting in the underlying cause give	n in Part i. 24a. WAS AN AUTOPS PERFORMED?					
200			1 YES 2 1440	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?				
ME				1 TES 2 NO				
ż	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA	ATH YES INO ID UNCER	TAIN 🗆	22-755				
CIA	25. WAS CASE REFERRED TO MEDICAL 26. PLAN EXAMINER? HOSPITAL:	CE OF DEATH (Check only one)						
PHYSICIAN: MEDIC	1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3	OTHER: 4 Nursing Home 5 Reside	nce 8 Other (Specify)					
F	27. MANNER F DEATH 1 Netural 5 Pending 28e. DATE OF INJURY (Month, Day, Year)	28b, TIME OF 28c, INJURY AT WORK?	28d. DEŞCRIBE HOW INJURY O	CCURED				
В	2 Accident Investigation	M 1 YES 2 NO						
	3 Suicide 8 Could not be determined 28e. PLACE DF INJURY — At his building, stc. (Specify)	ome, ferm, street, factory, office	28f. LOCATION (Street end Numb City or Town, State)	per or Rural Route Number,				
P.	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, de							
3 Suicide 8 Could not be determined 29. LOCATION (Street end Number or Rural Houte Number, City or Town, State) 29. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: Dn the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner estated.								
BE	296. SIGNATURE AND TITLE DICERTIFIER	290-LICENSE	NUMBER 29d. D/	ATE SIGNED (Month, Day, Year)				
0	Inhar Diamen	1)35	1334	12/15/94				
-	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITE	M 27) (Type, Print)						
	JOSEPH OF GREENWELL							
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Alia Churchen Rando	11						
	DEC 15 1994 Silva di marca con la constanta	A		DUMAN of Day 9/00				

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

94-7265-510 balh ITEMS: 23 aprt I,27 per MEO G-719 1//12/95 reb

1 - STATE REGISTRAR		STATE OF M	MARYL				OF H			MENTA	REG. NO.	E		
1. DECEDENT'S NAME (First Middle Leet)							2. DATE OF DEATN			3. TIME OF DEATN				
Conova	Genova	Genova Stokes							MONTH DAY		YEAR O A	0000 M		
4. SOCIAL SECURITY NUM	BER	5. SEX	6. AGE	(In yrs. last t	oirtnday)	IF UNDER	1 YEAR	IF UNDER	R 24 HRS.		OF BIRTN	1	S. BIRTNI	PLACE (State or Foreign
214-50-4034		1 □ M 2 文文		_	YRS.	MONTHS	DAYS	HOURS	MIN.		th, Day, Year)		Country M 2 T	
9a, FACILITY NAME (If not in		street and number)	4	5		9b. CITY	, TOWN O	R LOCATI	ON OF DE	ATH	15,19		NTY OF DE	RYLAND
1920 Ashland Avenue						T								
RESIDENCE OF DE							Jarc	TINO	16		n/a			
10a. STATE	10b. COUNTY 10c. CIT					, TOWN OR LOCATION					10d, INSIDE CITY			
MARYLAND n/a BALTIMORE MX ves 2 -								XX YES 2 NO						
10e. STREET AND NUMBER							101,	ZIP COD	E			10g. CITI	ZEN OF W	HAT COUNTRY?
	LAND_	AVENUE							2	1205		IINI	TED	STATES
11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES.						13.	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No— If yes, specify Cuban, Maxican, Puerlo Rican, atc.) 14. RACE — American Inc. Black, White, etc.						- American Indian, White, etc.	
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		COOR				AUUHES	S (Street ar	a Number	r or Hurai i	Houte Nun	nber, City or Town	n, State, Zip	Code)	
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K Buriel 2 - Crematic	on 3 🗆 Re	moval from State		netery, creme	story or oth	er place)				DA		CATION —		
4 ☐ Donation 5 ☐ Other		ICENCEE A	-	ARBU	TUS		MORIA NAME AN			12-	19 AI	RBUTL	JS, M	IARYLAND
Ro	/					22.	NAME AN	JAUUHE	SS OF PA	CILITY				
Dema	1 P	man				1	VIM.	. M	ARCH	FH.	-1101 i	E. NO	RTH	AVENUE
23. PART I. Enter the d	ilseseea, o	complications the	ceused	d the deet	h. Do n	ot enter	the mod	e of dy	ing, auc	h ss csi	rdiec or respin	ratory err	eat,	Approximate
IMMEDIATE CAUSE (Fir	Garage	K LISE Only one Cec	ee on e	ecn line.										Interval Between Onset and Death
disease or condition resulting in deeth)	\rightarrow	SEPSIS												
		DUE TO	(OR AS A	CONSEQU	ENCE OF):								
Commented that the state of		RENAL	ABSCE	SS CON	APL I C	ATING	NARC	OTIC	ABUSE	-				
Sequentially list condit if any, leading to imme	diete	DUE TO	(OR AS A	CONSEQU	ENCE OF):								
CAUSE (Disease or Inju		c	-											
thet initiated events resulting in death) LAS	7	DUE TO	DUE TO (OR AS A CONSEQUENCE OF):											
d														
PART II. Other significe	ent conditi	one contributing to	deeth b	ut not rec	uiting ir	the ur	nderlying	cause (given in	Part I,	24s. WAS AN	AUTOPSY	24b.	WERE AUTOPSY FINDINGS
							, ,				PERFOR			AVAILABLE PRIOR TO COMPLETION OF CAUSE
										_	1 YYES 2	□ NO		OF DEATN?
DID TOBACCO U	ISE CON	TDIBLITE TO CA	LICE O	E DEATI	U VE		NO I	LINIC	EDTAI					f YES 2 NO
25. WAS CASE REFERRED TO		TRIBUTE TO CA		28. PLACE				UNC	ERTAI	у Ц				
EXAMINER?		HOSPITAL:				OTHE	9 :	51222		1, 5				
27. MANNER OF DEATN	1	1 Inpetient 2 I			28b. TIME		sing Home	Δ	aldenca	_	er (Specify) SCRIBE NOW IN	I II I III OO	******	
1)(X) Natural	handing	(Month, D			INJU		WOF		1 40	28d. DE	SCHIBE NOW IN	IJURY OCC	URED	
a Carte	Investigation	28a DI ACE O	F IN HIRV	- At home	farm of			3 2	_ NO	204 1 0	DATION O	. 4 41 (2.4	0.110	
	8 Could not be detarmined 28e. PLACE OF INJURY — At home, farm, street, factory, offica bullding, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, offica City or Town, State)							oute Number,						
29a. CERTIFIER	_		_							_				
(Check only		SICIAN: To the best of												
X MED	ICAL EXAMI	NER: On the basis of a	aminatio	n and/or Inv	restigation	, in my c	pinion, de	eth occur	red at the	time, dat	a and placa, and	f due to the	e Cause(a)	and manner as stated.
29b. SIGNATURE AND TITLE	OF CENTIF	en Uli on			11			29c. LICE	ENSE NUN	BER		29d. DATE	SIGNED	(Month, Day, Year)
Moupe	EU U	e shell)		mo oc			o.c.	M.E. Dec		oc 1	4 1994		
30. NAME AND AODRESS OF	F PERSON V	HO COMPLETED CAUS	-											
MANUAD	6401	1 12 KD1	LEU	<u>ノ111</u>	l Pe	nn	Str	eet	, Ba	alti	more,	Mai	cyla	nd 21201
	Year)	32 REGISTRA	R'S SIGN	ATURE										
DEC 15	1994	Halia dil	nagan.	-Ravbo	\mathcal{M}_{i_1}									

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DIVISION OF VITAL RECORDS, P.O. BOX 6876

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

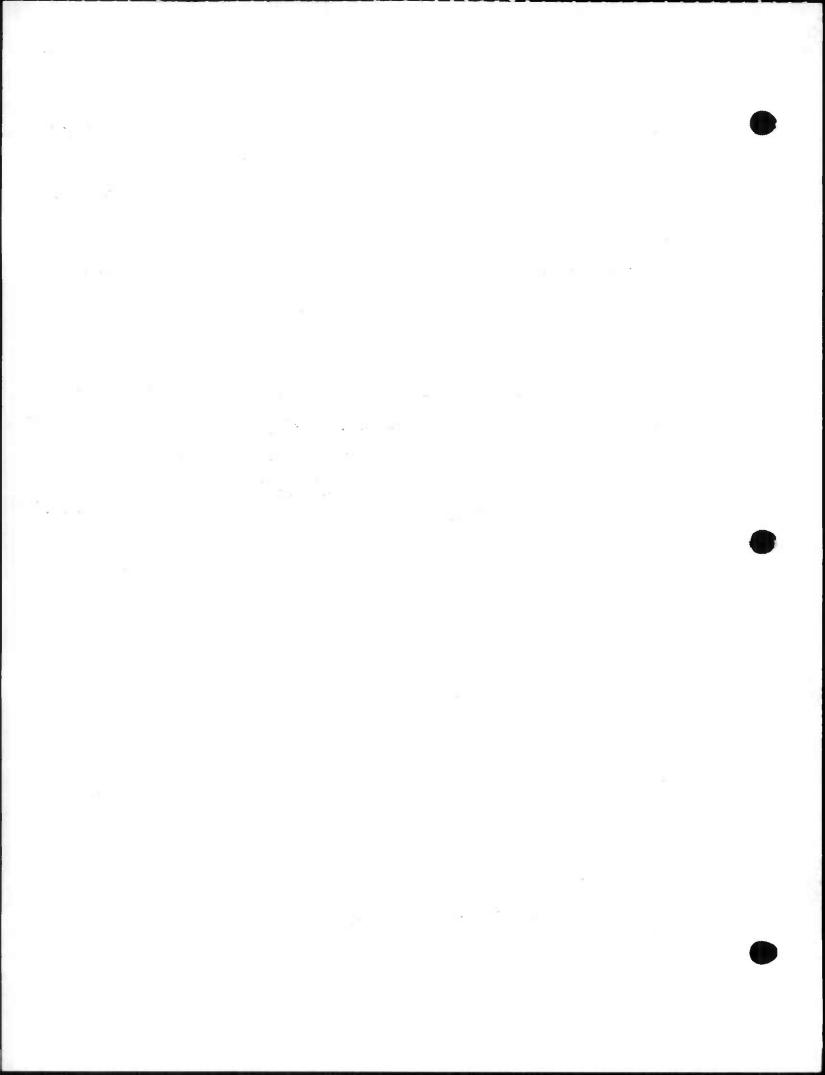
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within flours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	DAY	3. TIME OF DEATH		
	Yewell		well IF UNDER 1 YEAR		December 1	4, 199	4 12:30 P. M		
1 3	and the first state of the stat			HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)		8. BIRTNPLACE (State or Foreign Country)		
210 10 -1373 R 72			ar CITY TOWN	OR LOCATION OF D	April 1, 19		Maryland		
7016 Kenleigh Roa	Baltim		EAIN		timore County				
RESIDENCE OF DECEDENT				- Deter	cimore country				
		TOWN OR LOCATION							
Maryland Baltime	e County 1 ☐ YES 2 ☑ NO 100. ZIP CODE 100. CITIZEN OF WHAT COUNTRY?								
7016 Kenleigh Road		21212 U.S							
11. MARITAL STATUS 12	P. WAS DECEDENT EVER IN FORCES? 1 YES	U.S. ARMED		CENDENT OF NISPA	es or No-				
1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE WAR OR DA	ATES X		pecify Cuben, Mexic S 2 NO Speci		Specify:			
15. DECEDENT'S EDUCATI	ION	16e. DECEDENT'S	USUAL OCCUPAT	A.	16b. KIND OF B	Heiness (IND)	White		
(Specify only highest grade con			work done during m		IOU. KIND OF B	OSINESS/INDC	75181		
	2	Bookkee	eper		Teleph	one Co	ompany		
17. FATNER'S NAME (First, Middle, Last)				18. MOTNER'S N		Telephone Company ME (First, Middle, Meiden Surname)			
	C	Yewell	Yewell Mary			Evelyn I			
19e. INFORMANT'S NAME (Type/Print)					Route Number, City or To				
C. Kevin Sewell	l an	10602					lle, MD 21030		
20e, METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Removel 4 Donation 5 Other (Specify)	from State	etery, crematory or o	ther place)	al Cambone	Dec. 17 Lut	ocation — c	Olty or Town, State		
21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE/	urry van	22. NAME /	ND ADDRESS OF FA	CILITY		e, ratylati		
1 Som Sto	(a)				edefeld Ho		1 1 01010		
23/PART /. Enter the diseese, or com	plicatione that ceused	the deeth. Do r	not enter the m	ode of dying, suc	h se cerdisc or rea	ore, Ma	aryland 21212		
shock, or heart fallure. Lief	23 PART. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or reapiratory arrest, shock, or heart failure. Liet only one cause on each line. Approximate interval Between								
disesse or condition Suit Double - arrythmia VC MT									
disesse or condition	Sudden D	eath-	-arry	Yunia 1	IS MT		Onset end Daath		
disease or condition resulting in deeth)		eath-		Yunia 1	VS MT.				
disease or condition resulting in deeth)	DUE TO (OR AS A	CONSEQUENCE O	f):	Ymia 1	VS MT.				
disesse or condition resulting in deeth) Sequentielly list conditions, if any, leading to immediate	DUE TO (OR AS A		f):	Ymia 1	VS MT.				
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR. After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremoval.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTAL HYGIENI	E			
100	1. DECEDENT'S NAME (First, Middle, Last)		Jame:			2. DATE OF DEATH DATE 12-13-9	Y YEAR	3. TIME OF OEATH		
- 5	4. SOCIAL SECURITY NUMBER 212-40-0874	5. SEX 6. AGE (II	5 2 YRS.	at birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF			TE OF BIRTN S. BIRTNPLACE (State or Foreign Country)			
~	9e. FACILITY NAME (If not institution, give		96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH							
TOT:	2226 Penrose Baltimore									
DIRECTOR	Md . 10b. COUNT	10c. CITY	10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 TY YES 2 NO			
FUNERAL	106. STREET AND NUMBER 2226 Per		101. ZIP CODE 21223			10g. CITIZEN O	F WHAT COUNTRY? USA			
BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 X X Vorced	U.S. ARMED 2 NO TES					se or No- 14. RACE - American Indian, Black, White, etc. Specify: Black			
COMPLETED	(Specify only highest grade completed) (G			the kind of work done during most of working Do NOT use retired.)			.J. Reynolds			
OME	17. FATNER'S NAME (First, Middle, Last)		1 4 11.	1001	16. MOTNER'S NAI	ME (First, Middle, Malden S	_	Las		
BEC	Willie Sander:	S				ca Mae Ho				
6	19e. INFORMANT'S NAME (Type/Print)				and Number or Rural R	Route Number, City or Town	, State, Zip Code)	Code)		
	Dorothy A. Co.					N Baltim	ore, 1	MD 21223		
20g. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of competent), cremptory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of competent), cremptory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of competent), cremptory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of competent), cremptory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of competent) 20b. PLACE AND DATE OF DATE OF DISPOSITION (Name of competent) 20b. PLACE AND DATE OF DAT								ore, MD		
	21. SIGNATURE OF FUWERAL SERVICE LI	23 Marke and Appeless of Activation & Sons 1701 Laurens St., Balto., Md. 21217								
	23. PART i. Enter the diseases, or abock, or heart failure.	complications that caused List only one cause on es	the death. Do no	ot enter tha mo	de of dying, such	h as cardiac or reapin	atory srreat,	Approximate Interval Batween		
	IMMEDIATE CAUSE (Final disease or condition resulting in death) s. small cell carcing or of the lung one year.									
_	DUE TO (OR AS A CONSEQUENCE OF):									
ATIO	Sequentially list conditions, if any, leading to immediate Cause Frier UNDERLYING									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d										
	PART ii. Other significant condition	ne contributing to deeth by	it not reculting in	the underlying	t t- 1	B. 4.				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPS PERFORMED? 1 YES 2 NO						MED?	24b. WERE AUTOPSY FINDINGS: AMAILABLE PRIOR TO COMPLETION DF CAUSE OF GEATH?			
Lung concer metantati to brain							1 - YES 2 - NO			
AN	25. WAS CASE REFERRED TO MEDICAL		6. PLACE OF DEATH		UNCERTAIN	<u> </u>				
SIC	EXAMINER? 1 YES 2 W NO	HOSPITAL: 1 Inputient 2 ER/Output	itlent 3 DOA	OTHER: 4 Nursing Hom	e 5 X Reeldence I	8 - Other (Specify)	-			
Y PH)	27. MANNER OF OEATH 1 Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	D. TIME OF 18C. INJURY AT WORK? 1 YES 2 NO 28d. OESCRIBE HO			W INJURY OCCUREO			
COMPLETED B	2 Accident							al Route Number,		
PLE	29e. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my knowle	edge, death occurred	s at the time, date	end place, end due	to the cause(e) end mann	ner ee stated,			
Ö		ER: On the beele of examination						e(e) end manner ee stated,		
BE	29b. SIGNATURE AND TITLE OF CERTIFIE M CONS	10 0 -	Residut 1	Phosicin	AU 417	643S	29d. DATE SIGN	ED (Month, Day, Year)		
2	Mansor Shomali				K h	m Ma a	1201	-		
	21. DATE FILED (Movel). Day. Mary. # 32. REGISTMAN'S SUGNATURE									
	DEC 15 1994	Jaka Davidson Ka	Malle							

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BALTIMORE, MARYLAND 21215-0020

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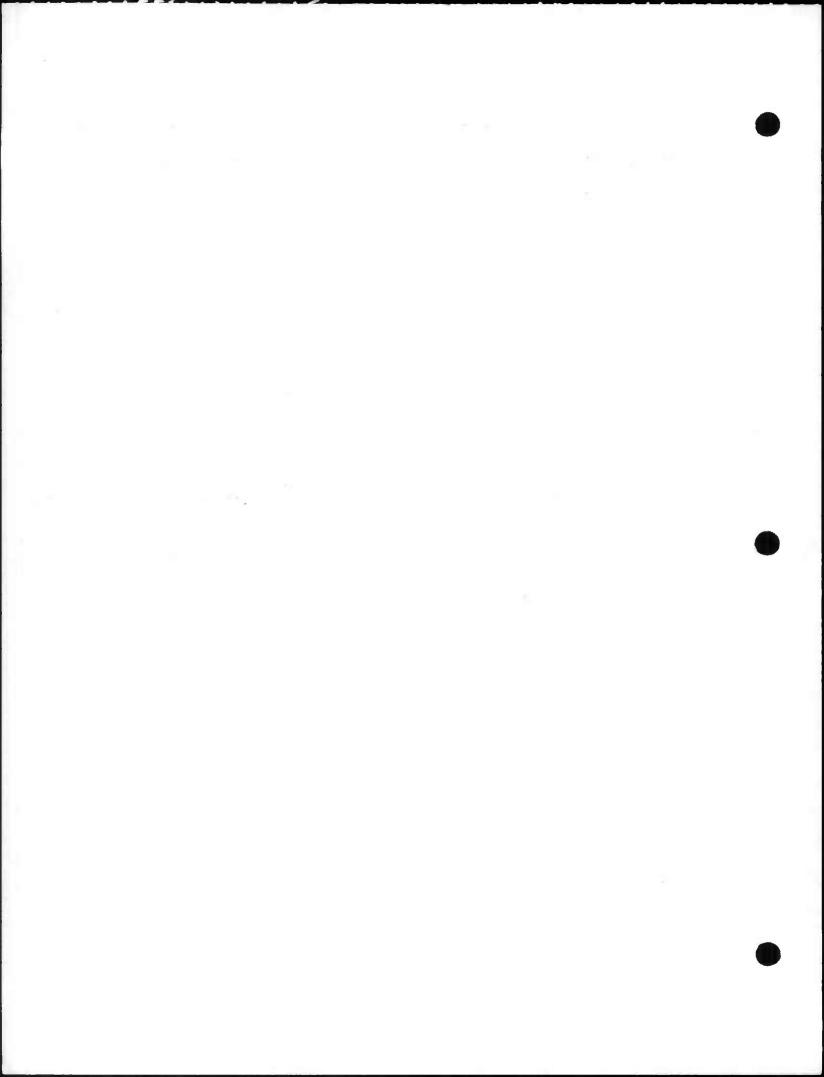
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The law requires that the death certificate be executed within so hours after death. Page 6 may be retained by the hospital or attending physician.

The law isqued by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be state Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal. TO THE HOSPITAL OR ATTENT TO THE FUNERAL DIRECTOR De filed within 72 hours from IMPORTANT. Il from

FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
ECEDENT'S NAME (First Middle Last)		A DATE OF BEATH

	1 - STATE REGISTRAR	SIAIE UF N		ERTIF						TGIEN EG. NO	E				
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF I	DEATH			3. TIME OF DEATH	٦	
	HELEN	SMAL	KIN						DEC.1	0.19		YEAR	4:15 A M		
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs.	lest birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE OF E	IRTH	7.5-4	8. BIRTH	PLACE (State or Foreign	۲	
	214-20-0162	1 🗆 M 2 🔀 F	87	YRS.	MONTHS	DAYS	HOURS	MIN.	JUNE	9,	1907	Countr			
	9e. FACILITY NAME (If not institution, give	street and number)			9b. CITY,	9b. CITY, TOWN OR LOCATION OF D						NTY OF D	TY OF DEATH		
SHO	BRIGHTWOOD MERI	ING HO	ME	В	ROOK	CLANI	OVILI	E		B	ALTIM	ORE	I		
DIRECTOR	RESIDENCE OF DECEDENT													Ⅎ	
HE	MD 100. STATE 106. COUNT	Y			y, town o BALTI		377						10d. INSIDE CITY LIMITS?	1	
	100. STREET AND NUMBER			<u>, </u>	DALLI								1 X YES 2 NO	┙	
RA		30			10f,	ZIP CODE						VHAT COUNTRY?	1		
FUNERAL	6300 RED CEDAR	PLACE A					212					USA			
	1 Never Merried 2 Merried	FORCES? 1	YES 2	KNO	1	yes, spe	cify Cuba	n, Mexicen	IC ORIGIN? (Se t, Puerto Ricer	, etc.)	or No-	Black	. — American Indian, t, White, etc.	ı	
3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 1 YES 2 NO Specify: Specify:									WHITE	ı					
0	15. DECEDENT'S EDI		18e. I	DECEDENT'S	USUAL OC	CUPATIO	N		16b. KIN	D OF BUS	SINESS/INI	DUSTRY	ANITIE	┨	
ᄪ	(Specify only highest grad Elementary/Secondery (0-12)	College (1-4 or 5 +		(Give kind of life. Do NOT u	work done d se retired.)	furing mos	t of workin	g						ı	
4PL		1.		HOU:	SEWIF	Έ				AT	HOME			1	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						1a. MOTH	IER'S NAM	AE (First, Middle	, Maiden	Surname)			1	
BE (JACOB BUR	K]	[DA		G.	AMSE				
2	19e. INFORMANT'S NAME (Type/Print)								oute Number, C					1	
	JUDITH ZLOTSKY			6369 .	STONE	BRI	DGE	RD,	SANTA					⅃	
	20e. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Ren	noval Irom State	20b. PLAC cemetery_c	E AND DATE	OF DISPOSI	TION (Nar	ne of	10	DATE			City or To		1	
	4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE	HE	BREW 1					-13-94	В.	ALTI	MORE,	MD	4	
	1 / 1 <	CENGLE						SS OF FAC	I & BRO)S. (INC			1	
_	- Juna		_		60	10 F	ETST	PERST	OWN RO	CAC	ват.т	TMORE	E, MD 21215	1	
	23. PART I. Enter the diseases, or shock, or heart failure.	complicatione that	ceused the	deeth, Do r	not enter	ths mod	le of dyl	ng, such	es cerdiec	or reepi	ratory er	rest,	Approximete interval Between	1	
	IMMEDIATE CAUSE (Finel	4											Onset and Death	ł	
	disease or condition recuiting in death)	· A/2	houn	2015	dis	0018	P						Years	ł	
	disease or condition recuiting in death) e. A 2 1											V	1		
8	Sequentielly liet conditions,	b	OR AS A CONS												
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	OOE 10	ON AS A CONS	EUUENCE U	r):									ı	
윤	CAUSE (Diseese or injury thet initieted events	c. DUE TO	OR AS A CONS	EOUENCE O	F):									-	
ᇤᅵ	resulting in desth) LAST													ı	
		0.												1	
CAL	PART II. Other eignificent conditio	1 1		t resulting	in the un	derlying	ceuee g	iven in F	Pert I. 24e	WAS AN	AUTOPSY MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	1	
5	Chronic ren	4 4 ci 11	IND ON	CONO	Mar	xy c	4/10	24	10	YES 2	010		COMPLETION OF CAUSE OF DEATH?	ı	
MED	disease								_				1 - YES 2 - NO	Į	
ÿ	DID TOBACCO USE CONT	RIBUTE TO CA					UNC	ERTAIN							
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PL	ACE OF OEAT	OTHER									-	
13S	1 TYES 2 THO	1 Inpatient 2			4 Nurs	ing Home	_	sidence 8	Other (Spi					J	
Ŧ	27. MANNER OF OEATH 1 Natural 5 Pending	28e. DATE OF (Month, Da		28b. TIM	E OF URY	28c. INJU WOF	IK?		28d. DESCRIE	E HOW II	NJURY OC	CURED		1	
6	2 Accident Investigation	04- 04-05-04	7 (6) (1) (6)			1 🗌 Y	ES 2 _	NO						1	
	3 Suicide & Could not be 4 Homicide determined	building,	FINJURY — At I	nome, term, s	streel, lecto	ry, office			City or Tox		ind Number	r or Runal A	oute Number,	l	
COMPLETED	29e. CERTIFIER													4	
MP	(Check only													ı	
ខ្ល	2 MEDICAL EXAMINI		aminimon end/o	r Investigatio	n, in my of	oinion, de	ath occun	ed at Jhe t	ime, date end	plece, en	d due to th	re ceuse(e)	end menner as stated.	l	
띪	296. SIGNATURE AND TITLE OF CERTIFIE	7/					29c. LICE	NSE NUM	BER		29d. DAT	E SIGNED	(Month, Day, Year)	1	
2	30. NAME AND ABORESS OF PERSON WI	O COMPLETED OF	E OF OFFI	FM 67 -	2-1-11		V	206	88		7 (4/1	0/74	1	
	Cods C	O COMPLETED CAUS	E OF DEATH (IT	EM 27) (Type,	Print)			41		-			/		
	ZIL DATE FILED (Mouth Com Worth	I. Storenton	No. 3	15	1-01 x	2010	creat	1/2	4,10	100	150	Ma	1. 21286	1	
	DECI 5 1994 9	WAY TO TO THE PARTY OF	-F-GHO-D-4												
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BALTIMORE, MARYLAND

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permit. Pages 1, 2, 3

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to notified 90 must medical examiner the event. traumatic or other any Shows 23 Hem

the attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or removal, signed by the Health a has been s Dept. of H this certificate h of the marked, DIRECTOR: After the bours after death of them 28 is mark TO THE FUNERAL De filed within 72 h

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

OR ATTENDING PHYSICIAN: The law

HOSPITAL

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Item9a, 9-718, 12-15-94, perf.h., dr STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 . CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH C 8:05 P ECEMBER 12 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year)
OCT. 2,1910 IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 - M 2 - KF 214-03-2944 84 MARYLAND 9a. FACILITY NAME (If no: 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH DIRECTOR UNIONA TIMOREC RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 YES 2 \(\) NO MARYLAND BALTIMORE FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6310 GREENSPRING AVE, APT. 403 21209 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 24 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 YES If yes, specify Cuban, Maxican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES KHETO-BY Specify: 3 Widowed 4 Divorced WHITE 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ntary/Secondary (0-12) College (1-4 or 5+) COMPL HOUSEWIFE AT HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) JULIUS DICKMAN **JENNIE** SAMUELSON BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MRS. SUSAN 7 HURSTON COURT BALTIMORE, MD 21208 ALPERSTEIN 20a, METHOD OF DISPOSITION 1 ☑ Burlal 2 ☐ Cremation 20b. PLACE AND DATE OF DISPOSITION /Name of 20c. LOCATION - City or Town, Stata DATE 4 Donation 5 Other Dec FRIEDEL MARYLAND LODGE 12-14-94 ROSEDALE, MD 21. SIGNATURE OF POWE RAL SERVICE LIDE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215 23. PART I. Enter the dises flone that coused the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, **Approximats** ehock, or heert fallure. List only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Finel Onset and Death disesse or condition ____ DUE TO (OR AS A CONSEQUENCE OF): neumouse CERTIFICATION Sequentially list conditions. if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury tueula DUE TO (OR AS A CONSEQUENCE OF that initisted events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 TES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH PHYSICIAN: YES \(\text{NO \(\text{\sqrt{NO kincertain}} \) 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 Sinpatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 286. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending В 1 YES 2 NO 2 Accident

28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide datarmined 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one)

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

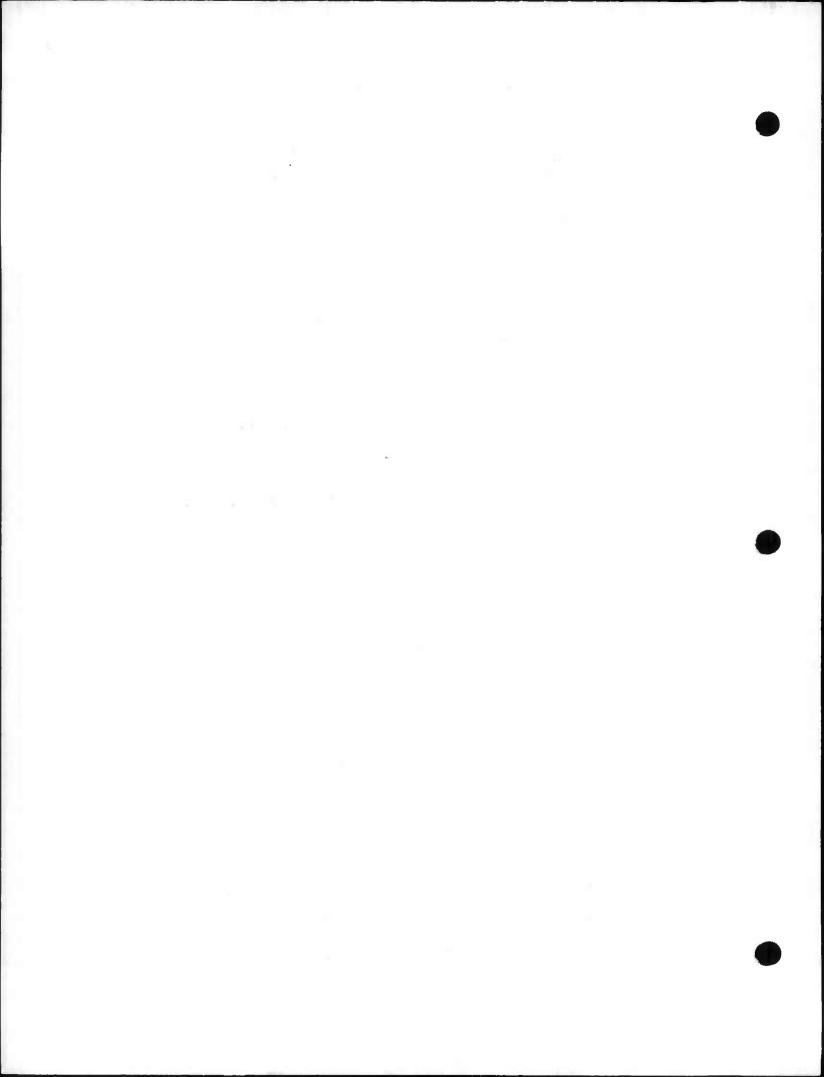
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DIVISION OF VITAL F	DR ATENDRIC STATE

		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ND / DEPART			MENTA	HYGIEN				
		1. DECEDENT'S NAME (First, Middle, Lest)	Elizabeth	P. Sha	ffer		MONT	OF DEATH D		EAR 3.	TIME OF DEATH	
9		213-20-6603	5. SEX 8. AGE (In)	IF UNDER 24 HRS. HOURS MIN.	FUNDER 24 HRS. OURS MIN. 7. DATE OF BIRTN (Month, Day, Year) 02/07/1923 Balto.							
2, 3 should	TOR	90. FACILITY NAME (If not institution, give street 1402 Medfield RESIDENCE OF DECEDENT		9		or Location of D					N	
permit. Pages 1,	DIRECTOR	100. STATE 10b. COUNTY MD Cit	У	TION Baltimo	ore	10d. INSIDE CITY LIMITS? XIX YES 2 \(\text{NO} \) NO						
:5	FUNERAL	100. STREET AND NUMBER 1402 Medfield Av	enue		10	2121	1		1 *	2. CITIZEN OF WHAT COUNTRY?		
5-0020 nding physician. Is the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3. Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 TNO	If yes, sp	CENDENT OF NISPA pecify Cuben, Mexico S 2 NO Specif	an, Puerto		e or No— 14		American Indian, Thite, etc. White	
or afte	ETED !	15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondery (0-12)	TION 10 Impleted) College (1-4 or 5 +)	8e. DECEDENT'S US (Give kind of wor life. Do NOT use i	SUAL OCCUPATI k done during me	ON	168		SINESS/INDUS			
AND he hospit detached		12th 17. FATHER'S NAME (First, Middle, Last)		Secret	ary	18. MOTHER'S NA	AME (First,			Нор	kins	
MARYL retained by the S should be at the	ш	19a. INFORMANT'S NAME (Type/Print)	Samuel E.	19b. MAILING A		Pear	Route Num	ber, City or Tow		,		
RE, may be		Betty Lou Etzel 20e. METHOD OF DISPOSITION (W. Burlet 2 Cremetton 3 Remove 4 Donetton 5 Other (Specify)	mi from State comete	LACE AND DATE OF	DISPOSITION (N		DAT	E 20c. LO	heste	y or Town,	State	
SALTIN r death. Pag e funeral dir al.		21. SIGNATURE OF FUNERAL SERVICE LICEN	P Carpe	nles	Burg	tery NO ADDRESS OF FA ee-Hens Falls	SS F	unera	l Hom	ie	MD 21211	
d within Schours after d mpletely filled in by the standard or cremation, or removal.		23. PART I. Enter the diseases, or conshock, or heert failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	mplications that seused it st only one ceuee on each	h line.	enter the mo	ode of dying, suc	h as cen	ilac or reep	Iratory arres	t,	Approximata Interval Batweer Onset and Death	
P.O. BOX 687 th certificate be execute anding physician and co I Hygiene prior to burial or other traumatic	RTIFICATION	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	OUE TO (OR AS A CO									
signed by the Health and M	S	PART II. Other algoriticent conditions	contributing to deeth but	not resulting in	the underlyin	g cause given in	24a. WAS AN PERFOR	ORMED? AN		RE AUTOPSY FINDINGS ARIABLE PRIOR TO IMPLETION OF CAUSE DEATH?		
AL MI ne law rec has been Dept. of	A.	DID TOBACCO USE C	ONTRIBUTE TO	CAUSE OF		YES NO	- 2	100		_ ''	YES 2 NO	
SICIAN: The State the State	PHYSICI.		HOSPITAL: I Inpatient 2 ER/Outpatk 28s. DATE OF INJURY	ent 3 DOA 4	OTHER: Nursing Non 28c, IN.	ne 5 Residence	6 🗆 Othe	r (Specify)	NJURY OCCU	REO		
	B	1 Naturel 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be	(Month, Day, Year) 28a. PLACE OF INJURY — building, etc. (Specify)	At home, larm, atre	M 1 🗆	YES 2 NO	28f. LOC	ATION (Street	end Number or		e Number,	
LOR TE	COMPLETED	4 Nomicide determined	AN: To the bast of my knowled		at the time, date	and place, and due		or Town, State)				
TO THE HOSPITAL TO THE FLINERAL De fied within 72 IMPORTANT: H	BE COM		On the basic of axamination e				time, data		nd due to the o	ause(e) an	onth, Day, Year)	
E E S M	TO B	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH			1023319 12-13-9					-94	
(12)		31. DATE FILED (MONTH) DENOTED THE	MI) (34	AL A	V.CHV	RLES	<u>E</u>	1ACT	- 2	121,	2	



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DIVISION OF VITAL RECORDS, P.O. BOX 88/60.	DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with rouns after death. Page 6 may be retained by the hospital or attending

SALIMONE, MANIETTE CONTROLL MANIETTE CANDER CA	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with wours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	THE CA	THE CH	De filed	IMPOF

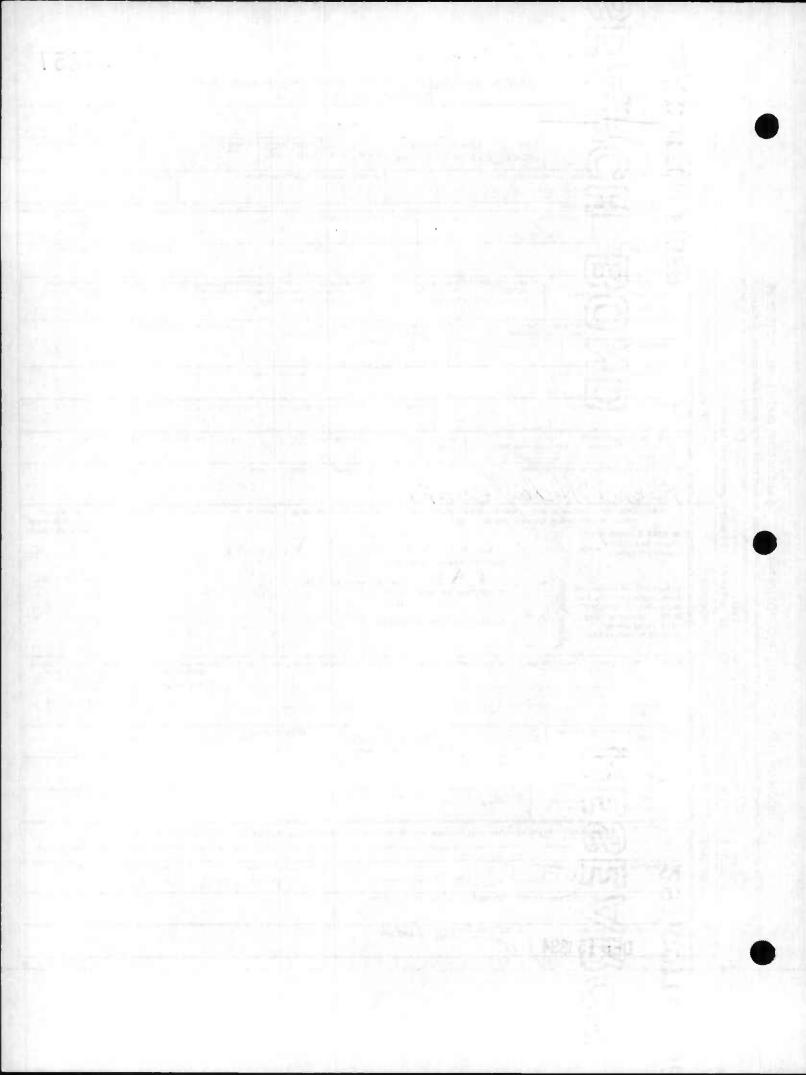
	1. DECEDENT'S NAME (First, Middle, Last) CHARLES TRUITT	_ Charle		Truitt			2. DATE 6 MONTH 12		3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 217-01-1462-A	5. SEX 1 → M 2 → F	6. AGE (In yrs. Is	ist birthday) IF U	HDER 1 YEAR	IF UNDER 24 HRS	7. DATE (OF BIRTH (I	94 5:45 P BIRTHPLACE (State or Foreign Country)			
	Se. FACILITY NAME (If not institution, give s	71	92	-	CITY, TOWN (OR LOCATION OF	May 2		Maryland Y OF DEATH			
ב	RIVERVIEW NURSI		E. INC		BALTIM			N//				
	RESIDENCE OF DECEDENT											
	MADITE AND	arford		10c. CITY, TOV					10d. INSIDE CITY LIMITS? 1 ☐ YES 2\(\frac{1}{2}\) NO			
	10e. STREET AND NUMBER	arroru			Fallst	. ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?			
	3205 Suffolk Lane					21047		US	Δ			
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1	AS DECEDENT EVER IN U.S. ARMED ORCES? 1 V YES 2 NO YES, GIVE WAR OR DATES 13. WAS DECEMDENT OF If yes, specify Cuben 1 YES 2/17 NO					? (Specify Yes or No- 1	4. RACE — American Indian, Black, White, atc. Specify: White			
	15. DECEDENT'S EDU (Specify only highest grade	completed)	(4	ECEDENT'S USUA Give kind of work di a. Do NOT use retin	one during mo		16b.	KIND OF BUSINESS/INDU				
COMPLETICE	Elementary/Secondary (0-12)	College (1-4 or 5 +)	Warehous				Electric	cal			
	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S	NAME (First, M	fiddle, Malden Sumame)				
	Antonie Trui	tt		DE MANUE ADD	ECC /Church	UNK		- 01 - 7 - 0 - 7 - 0				
		9e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chapless 1 TDLITTT ID 2005 See Solly Long Solly See Solly Long Solly See Solly Long Solly S										
	Charles J. Trutt Jr. 3205 Suffolk Lane Fallston Maryland 21047 20s. METHOD OF DISPOSITION 1 Of Burdel 2 Cremation 3 Removal from State 20b. PLACE AND DATE Of DISPOSITION (Name of Computer v. comp											
	4 Donation S C Other (Specify)		Baltin	one. (Man	land)C	emeterv	12/1	5 Baltim	ore. MAryland			
	21. SIGNATURE OF FUNERAL SERVICE U	la de	Drank	3.	22. NAME AI	ND ADDRESS OF Mitc	hell-Wi	edefeld Hame				
	23. PART I. Enter the diseases or	complications that	t coused the d	eeth. Do not er	nter the mo	OO YOYK R	Road Bal	timme Maryla	and 21212			
	shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition	/			1				Onset and Dea			
H	resulting in death)	a. DUE TO	(OR AS A CONSE	EQUENCE OF:	cijai	Fai	COLE		18 WG			
		aF	J& be	evo sc	Lero	212			20 40			
	If any, leading to immediate		(OR AS A CONSE									
	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	e. DUE TO	(OR AS A CONSE	OUENCE OF):								
	PART II. Other algorificent condition	a contributing to	deeth but not	24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
									1 TYES 2 NO			
	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PI	ACE OF DEATH	(Check only one	9)				
	1 VES 2 WATO	HOSPITAL:	ER/Outpatient		HER: Mursing Horr	e 5 🗆 Residend	e 6 🗆 Other	(Specify)				
	27. MANNER OF DEATH 1 ① Metural 5 □ Pending		a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 1NJURY AT WORK? M 1 YES 2 NO						RED			
	2 Accident Investigation 3 Suicide 6 Could not ba determined Phomicide City or Town, State) 29e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State)											
			(4,000,000,7)									

DR. MICHAEL SUTER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) UTER FRANKLIN SQUARE HOSPITAL

32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89



in. ansit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY FUN	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
in torreral offection, page 3 should be detached for use as like building.	be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
he funeral director, page 5 should be detached for use as the burial-tra	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-fr
r death. Page 6 may be retained by the hospital or attending physicia	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a hours after death. Page 6 may be retained by the hospital or attending physicia

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Day, Year)
DEC 15 1994

32. REGISTRAR'S SIGNATURE

TCCMIJ 12-1	J-74 III	IIIG/IO W	• II • F €	SI F	/ n				-	14 3	1230
FOR 1 - STATE REGISTRAR	STATE OF MA					EALTH AND DEATH	MENTA		E		
1. DECEDENT'S NAME (First, Middle, List)		CEI	MIIF	CATE	UF	DEATH	I a corr	REG. NO.		Tab	
Catherine	Eliz	abeth	7	Web	er		MON	ember		1994	63°am
212 24 4467	5. SEX	76		IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH	18	8. BIRTHPLAC Country) Mary	E (State or Foreign
9e. FACILITY NAME (If not institution, give stree	et end number)		-	9b. CITY	TOWN O	R LOCATION OF D		2		NTY OF DEATH	
1206 Middle Riv	er Road	l 			-	e Rive				timor	
10e. STATE 10b. COUNTY			10c. CITY,	TOWN C	OR LOCATI	ON				10d	. INSIDE CITY
Marvland Baltin	nore		Dun	da1	2					1.	YES 2 NO
10e. STREET AND NUMBER			2000	10101	10f.	ZIP CODE			10g. CIT	ZEN OF WHAT	
707 Wise Aye.						21222			U	SA	
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	2. WAS DECEDENT FORCES? 1 FYES, GIVE WAI	YES 2 NO	EO)	1 1	If yes, spe	ENDENT OF HISPA city Cuben, Mexic 2 NO Speci	en, Puerto		or No—	Black, Wh Specify:	
15. DECEDENT'S EDUCAT	TION		EDENT'S U				16	b. KIND OF BUS	INESS/INC		White
	mpleted) College (1-4 or 5+)	(Give	kind of wo Oo NOT use	retired.)	during mos	t of working					
11		Н	omem	ake	er			Own	Home	e	
17. FATHER'S NAME (First, Middle, Last)			-			16. MOTHER'S N	AME (First,	Middle, Maiden	Surname)		
	eland (Marti				azier	
19e. INFORMANT'S NAME (Type/Print)						d Number or Rural				۷.	1220
Patricia L. Mags	amen	112	206	Mid	ldle	River		ed, Ba	ltji	more,	MD
1 Buriel 2 Toperention 3 Remove 4 Donation 6 Pother (Specify)	I from State	20b. PLACE AN cemetery, creme	atory or other	er place)						City or Town, S	
21. BIGNATURE OF TYNERAL SERVICE LICEN	ISEE /	L HTTT	-op	Ser	NAME AND	e Corp	12/	112/94	To	wson,	MD
Man 5	1/1			D.,	922	WISE	Ave.	Dund	alk	, MD	21222
23. PART I. Enter the diseases or con	nolications that	numed the deal	h Do no			Ruck P					
shock, of heart failure. Lis	t only one ceus	on each lina.	III. DO 110	t enter	uie inoc	e or dying, au	cn aa cer	ulac or reepii	atory en	reat,	Approximate Interval Between
immediate cause (Final disease or condition	EMPH	YCEMI	Δ							ł	Onset and Death
reaulting in death) a		R AS A CONSEQU								<u> </u>	
										ļ	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (O	R AS A CONSEOU	ENCE OF):								
CAUSE (Disease or injury that initiated events	DUE TO (O	R AS A CONSEQU	IENCE OF):	:							
resulting in deeth) LAST											
PART II. Other algnificent conditions of	contributing to d	eath but not rea	euitine In	the un	deciving	ceuse alven la	Dort I	24s. WAS AN	ALCTON DO	1	
			outing in	the di	derrying	couse given ii	roit i.	PERFOR	MED?	AVAJ	LABLE PRIOR TO IPLETION OF CAUSE
							_	1 🗌 YES 2	NO	OF C	DEATH?
DID TOBACCO USE CONTRIE	BUTE TO CALL	SE OF DEATH	H YES	M	ио П	UNCERTAI	N []			1	YES 2 NO
25. WAS CASE REFERRED TO MEDICAL	701210 0/10	26. PLACE				OTTCERIA					
	OSPITAL:	R/Outpatient 3		OTHER		5 Residence	6 🗆 Oth	er (Specify)			
27. MANNER OF DEATH	28e. DATE OF IN (Month, Day,		28b. TIME INJUI		28c. INJU WOR	RY AT	28d. OE	SCRIBE HOW IN	JURY OC	CURED	1
1 Natural 5 Pending 2 Accident Investigation				М		S 2 NO					
3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF I	NJURY — At home c. (Specify)	e, term, str	eet, lect	ory, office			CATION (Street er or Town, Stete)	nd Number	or Rural Route	Number,
29e. CERTIFIER					_						
(Check only one) 1 CERTIFYING PHYSICIA MEDICAL EXAMINER:											
29b. SIGNATURE AND TITLE OF PERTIFIER			ugation,	,y O				e end piace, end			
STATE OF THE PARTY	0					29c. LICENSE NU	MBER		29d. DAT	E SIGNED Mon	th, Pay, Year)
30. NAME AND AODRESS OF PERSON WHO C	OMBI EVEN ONLINE	05 05 1711 07 07 07							- /	-/10	177

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760. FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

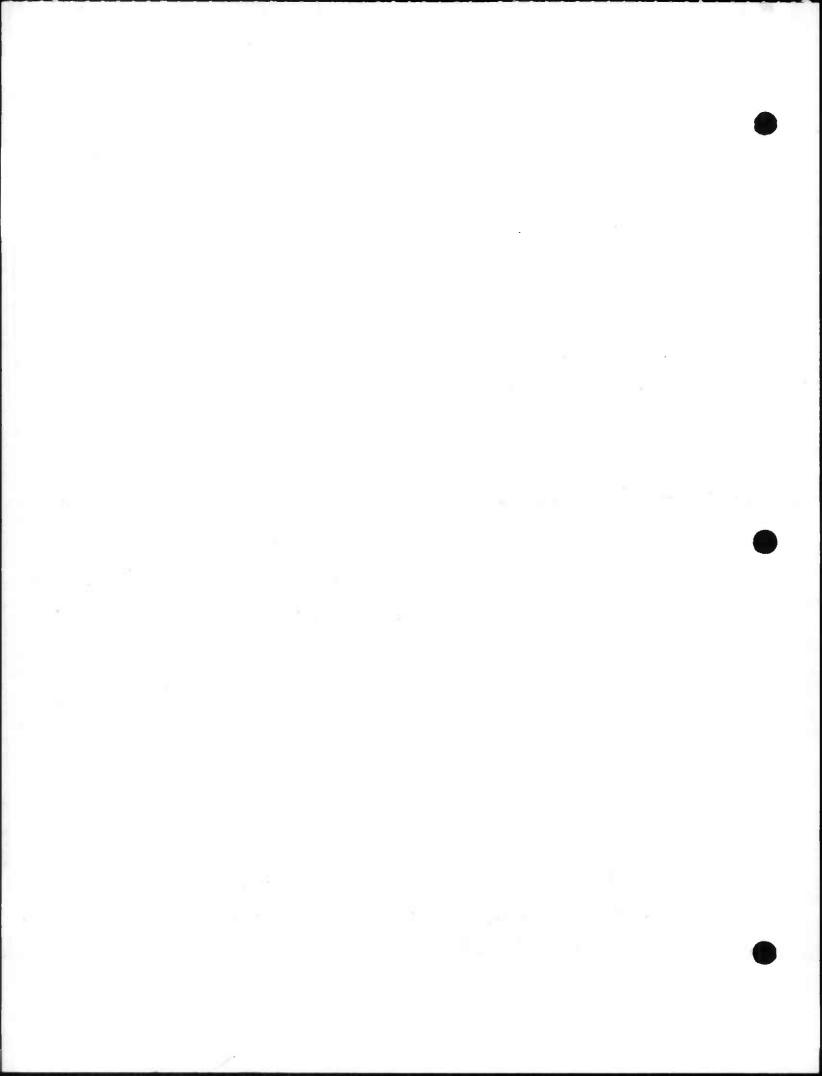
		REGISTRAR			CERTIF	ICALE	OF DEA	IH		REG. NO),		
		1. DECEDENT'S NAME (First, Middle, Last) SIDNEY				WEID	ERHORN		2. DATE MONTH DEC	of DEATH	, 1994	YEAR	10:30 A. M
		4. SOCIAL SECURITY NUMBER	5. SEX		yrs. last birthday)	IF UNDER 1 Y	EAR IF UNDER	R 24 HRS.		Dey, Year)	-		LACE (State or Foreign
교		021-12-0789	1 📉 M 2 🗆 F	71	YRS.	months b	HOURS	JUL				SSACHUSETTS	
3 should	~	9a. FACILITY NAME (If not institution, give s				9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH D. A.T. ITIT MODE:						АТН	
ci .	стов	5004 PATTERSON AV	E.		BALTIMORE								
Jes 1,	FUNERAL DIRECT		E 10b. COUNTY 10c. CITY, TOWN OR LOCATION										IOd. INSIDE CITY
F. Pa		MARYLAND			BA	LTIMOR	E					1	LIMITS?
bermi		10e. STREET AND NUMBER				10f. ZIP COD			10g. CITIZE	N OF WH	IAT COUNTRY?		
physician. burial-transit permit. Pages	ᇤ	5004 PATTERSON	AVE.				212			USA	7		
ysicia ırial-tı	E E	11. MARITAL STATUS Never Married 2 Merried	12. WAS DECEDENT FORCES?	T EVER IN L	J.S. ARMED 2 NO	13. WAS	DECENDENT	OF HISPAN	IIC ORIGIN	(Specify Yes	or No- 14	I. RACE - Bleck,	- American Indien, White, etc.
ing pt	BY	3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DAT	ES		YES 2 NO			,		Specify:	
e as I	ED	15. DECEDENT'S EDU	CATION		- ARMY	USUAL OCCL	PATION		16b.	KIND OF BU	SINESS/INDUS		HITE
al or atte		(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of a	work done duri se retired.)	ng most of worki	ing					
the hospital detached once.	COMPLET	12			MANAGE	R			V	ALLPA	PER S	tore	
the host	00	17. FATHER'S NAME (First, Middle, Lest)		m	2110221					iddle, Maiden		22200	
ed by	B	SAMUEL	V	AE TDEI	RHORN			ENNII				BARON	N
5 should notified	2	190. INFORMANT'S NAME (Type/Print) MR. MORRIS WEID	FDHODN		19b. MAILING	ADDRESS (S	reet end Numbe	er or Rural R	Route Numb	er, City or Tow	n, State, Zip C	ode)	
ay be		20e. METHOD OF DISPOSITION	LIMORW	20h B	LACE AND DATE	ARKER		NEWTY		IA 021		T	urani
ector, permanent		1 Donation 5 Other (Specify)	oval from State	cemete	ery, cremetory or o	ther place)		70/	DATE		CATION — CH		n, State
Page al dire		21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	L SH	ARON ME	MORTAL 22. NAI	PARK ME AND ADDRE	ESS OF FAC	LI3/92	LI_S	HARON	MA_	
ter death. Page 6 m the funeral director, wal.		· Sint W	1 Cita	4/1			LEVINS						
rs after of the removal.		23. PART I. Enter the diseases, or	complications that	1/V	he death Do	_6010	REIST	FRTO	WN RI) BA	OT.I	MD	21215
h at hour hour hy filled in attion, or the me		shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	Liat only one cau	se on eac	sclerot							τ,	Approximate Interval Between Onset and Desth
completely ial, cremati event, t	İ	rooding in death)	DUE TO	(OR AS A C	ONSEQUENCE OF	F):							†
and and hari	CERTIFICATION	Sequantially list conditions, if sny, laeding to immediate cause. Enter UNDERLYING	b	OR AS A O	ONSEQUENCE OF	F):							
he death certificate be the attending physician Mental Hygiene prior to njury, or other traun	TIFIC	cause. Entar UNDERLYING CAUSE (Disease or Injury that Initiated events C. Due TO (OR AS A CONSEQUENCE OF):											
ath cath cath trail Hy	Ä	resulting in death) LAST											
the deat y the att id Menta injury,		PART II. Other significant condition	s contributing to	death but	not reaulting	in the under	rlying causa	given in 1	Part I.	24s. WAS NN			VERE AUTOPSY FINDINGS
igned by ealth and	EDICAL		More							PERFOR		C	MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
requires een signe of Healt	MEC										X		YES 2 NO
law re as bee Dept. o 23 sh	AN:	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF	DEATH YE	S D NO	UNC	CERTAIN	1 🗆				
SiCIAN: The law requestrificate has been the State Dept. of 1, or Item 23 sho	SICIA	2S. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26	. PLACE OF DEAT	OTHER:	one)						
CIAN ertific the S	HYS	27. MANNER OF DEATH	1 Inpetient 2			4 - Nursing	-	leeldence		_			
野難	6	1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF (Month, De	ay, Year)		M 1	WORK?	□ NO			NJURY OCCU		
OR ATTENDING DIRECTOR: After hours after death item (8 is ma	TEG	3 Suicide 8 Could not be determined	building,	etc. (Specify)	At home, term, s	Preet, factory,	office		28t, LOCA City o	TION (Street e r Town, Stete)	end Number or	Rurei Rou	ile Number,
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	COMPL	MEDICAL EXAMINE											and matther ee stated.
TO THE HOSPI TO THE FUNER De filed within IMPORTANT:	O BE	Stand) Gelland	Deputy M	elka) BXAW	NA	De Lic	010	185	_	N.		North, Day, Year) 3, 1994
		Dr. Stanley F		C-100 223 V		se St.	Balti	.more	, MD	21202	2		
V		31. DATE FILED (Month, Day, Year)	32. REGISTRAI	_									
		DEC1 5 1994 Ju	in Develor	Marda	u.								

		t. Pages 1, 2, 3 should
0020	physician.	burial-transit perm
BALTIMORE, MARYLAND 21215-0020	ter death. Page 6 may be retained by the hospital or attending physiciar	the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
BALTIMORE, I	ler death. Page 6 may be	the funeral director, page

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

I or attendir	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or a	pinous 9
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		FOR 1 - STATE REGISTRAR	STATE OF MARY		DEPAR					MENTAL HYGIEN			
	ļ	1. DECEOENT'S NAME (First, Middle, Last)								2. DATE OF DEATH MONTH D	AY	YEAR	3. TIME OF DEATN
		<u>EVELYN</u> ZELLE								DECEMBER	1.1	994	22:30 M
		4. SOCIAL SECURITY NUMBER 212-36-0176	5. SEX 6. AGE	(In yrs. las	st birthday)	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) 10-28-38	,	8. BIRTI	HPLACE (State or Foreign BY) RYLAND
		9e. FACILITY NAME (If not institution, give a		76	rno.	9b, CITY	TOWN O	R LOCATIO	ON OF DE			INTY OF D	
DIRECTOR		THE JOHNS HOPKI						ORE			30.000	Ner Or C	rea(n
E		10e. STATE 10b. COUNT	Y	_	10c. CIT	Y, TOWN C	OR LOCAT	ION					10d. INSIDE CITY
	. 14		то. со.										LIMITS?
FLINERAL		3802 MAYBERRY	RD.					120			1 "	SA	WHAT COUNTRY?
Ž		11. MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. AF	RMED	13.				HC ORIGIN? (Specify Ye		14. RACI	E — American Indian,
	- 11	1 Never Married 2 Married 3 Vidowed 4 Divorced	FORCES? 1 YES		NO			2 NO		n, Puerto Ricen, etc.)		Blac Spec	k, White, etc.
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ETE		(Specify only highest grade Elementery/Secondary (0-12)	completed) College (1-4 or 5 +)	(G	ive kind of a	work done i	during mos	st of workin	9	160. KIND OF BU	SINE SS/IN	DOSINI	
once.		12 YEARS		SE	EAMS	TRES	SS			D M B	MAN	UFAC	CTURING
~ -	- 11	17. FATHER'S NAME (First, Middle, Last) CHARLES NEUNSIN	NCE P							ME (First, Middle, Maiden RINE SM.	,		
B 8	- 11	190. INFORMANT'S NAME (Type/Print)	NGE.R	19	b. MAILING	ADDRESS	S (Street e			Oute Number, City or Tow		n Godel	
TO		MR. KEEFER ZELL	ER SR.							BALTO. MO		1206	5
examiner must be		20e. METNOD OF DISPOSITION 1 General 2 Cremetton 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cametary or other place) 20c. LOCATION — City or Town, State											
Ter III		Donetion 5 ◯XOther (Specify) ◯ \ Signature of Fuheral Service Lie		JARL	JE NS		FAI	D ADDRES	SS OF FA		AL TO	. 00). MD.
xamir	1	Marin RX	Language	1.		KA	CZO	ROW:	SKI	FUNERAL			
medical	1	23. PART i. Enter the diseases, or o	complications that cause	d the de	ath. Do r	ot enter	the mo	DUNI	DAL P	AVENUE	BAL Iratory ar	TO.	MD. 21222
	ı	ahock, or heart failure. List only one cause on each line.										Interval Between Onset and Death	
ıt, the		disease or condition resulting in death)	. Trus	is	1	M	um	00	مصر	X			Memilia
event,		_	DUE TO (OR AS	A CONSE	OHENCE OF	r):	V	ine		1	0.	đ	Home
y, or other traumatic		Sequentially list conditiona, if any, leading to immediate	DIR TO (OR AS	A CONSE	DUENCE OF	7	7			cong.		~	,,0
T S		Cause. Enter UNDERLYING CAUSE. (Disease or injury C. Due TO (OR AS A CONSEQUENCE OF): UNDERLYING CAUSE. (Disease or injury C. Due TO (OR AS A CONSEQUENCE OF):											
or other		that initiated events resulting in death) LAST	DUE TO (OR AS	A CONSE	DUENCE OF	n.							0
= 1	- 11	DADT II Cober plentitions and dates	d										
any inju		PART ii. Other significant condition	a contributing to death	but not r	eauiting	in the un	derlying	cause ç	given in	PERFO	MED?	246	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
25 III	1									1 YES 2	NO		OF DEATN?
AN: M		DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	OF DEA	TH YE	S 🗆 I	10 D	UNC	ERTAIN	<u>-</u>			1 YES 2 NO
item 2		25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HQSPITAL:	26. PLAC	E OF DEAT	TH (Check							
5 ×		1 YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER/Out	patient 3	DOA 28b, TIM	4 🗆 Nun			eldence	6 Other (Specify)	N KIRV OC	- CURED	
5 G		1 Natural 5 Pending	(Month, Day, Year)			URY M	WO		NO	28d. DESCRIBE HOW I	NJUHY OC	CURED	
.º 0		3 Suicide 6 Could not be	28e. PLACE OF INJUR building, atc. (Spe	Y — At ho	me, farm, s	street, fact	ory, office			26f. LOCATION (Street City or Town, State)	and Numbe	r or Rurai I	Route Number,
m 28 ETE	ı	4 Nomicide determined						<u> </u>		ony or rown, orano,	-		
MPLE	ı		CIAN: To the best of my known. R: On the besie of examination										
COM	ŀ	296, SIGNATURE AND TITLE OF CERTIFIES	-	nr endor	iiiveatigatio	n, in my o	pinion, de						
IMPORTANT: IF		(legue) a	Maky	m)	3			M	40	747	290. DAI	12/12	(Month, Day, Year)
≧ 2	I	JO NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE OF DE							11010	_	-	4
	-	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN		N. (Noc	₹E	24	- +	GRUEY	€0 S	. 13	ALT 21287
		DEC1 5 1994	1. As in P	0 40									



BALTIMORE, MARYLAND 21215-0020

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TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the feath. Page 6 may be retained by the hospital or attending physician.

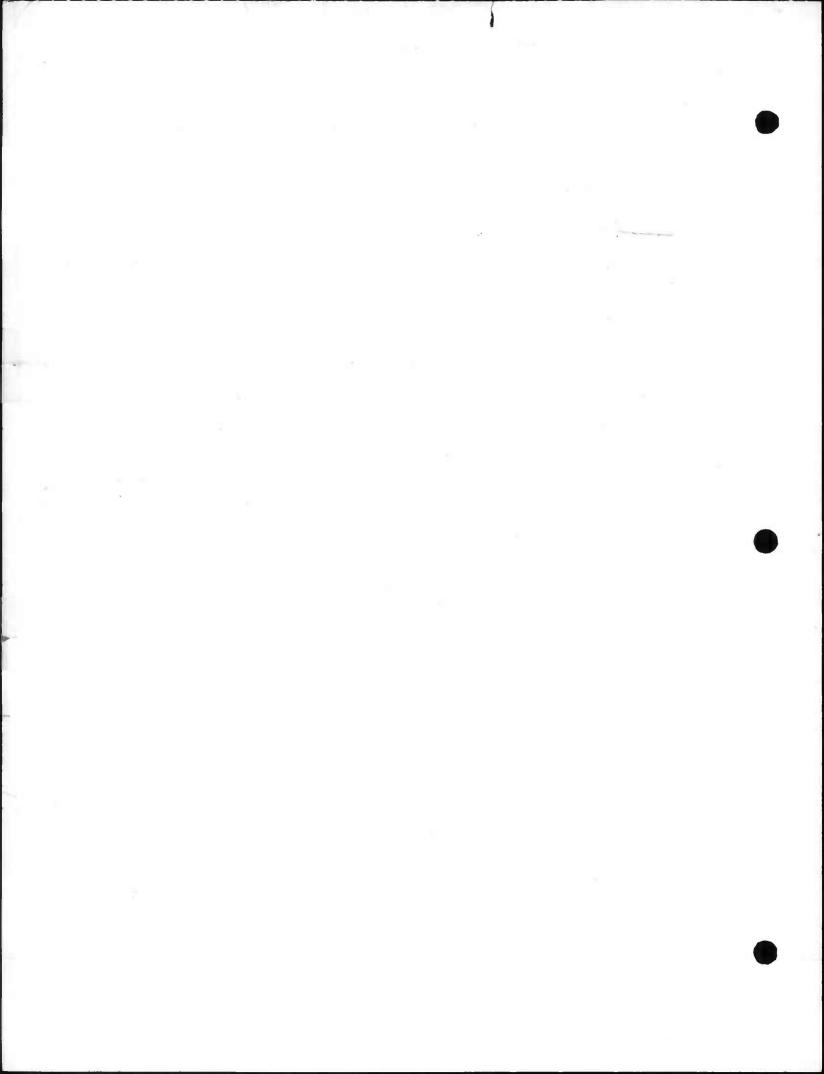
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

REGISTRAR	STATE UF MAKYL		MENT OF H		MENTAL HYGIEN REG. NO			
	AWORSKI				12 1	av year 2 94	5:15 P	
4. SOCIAL SECURITY NUMBER 214-03-2372	1 □ M 2 ☒ F		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 6 - 6 - 18	95 MA	THPLACE (State or Foreign PAYLAND	
	RSING CENTRE,		BALTO,	MD	EATH	BAL	TIMORE CO.	
MARYTAND			TOWN OR LOCAT			100		
104. STREET AND NUMBER 806 S. ROSE S	EET AND NUMBER			21224		USA	1 YES 2 NO	
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR E	2 XHO	If yes, spe	ENDENT OF HISPA	NIC ORIOIN? (Specify Yearn, Puerto Rican, etc.)	or No— 14. RA Bit	CE — American Indian, ack, White, etc.	
15. DECEDENT'S EL (Specify only highest gre Elementary/Secondary (0-12) 4 YEARS	DUCATION ade completed) College (1-4 or 5+)	16e. DECEDENT'S US (Give kind of wo life. Do NOT use HOMEMA	ork done during mos retired.)		16b. KIND OF BU	SINESS/HOUSTRY		
17. FATHER'S NAME (First, Middle, Last) IGNATIUS RYBA	RCZYK			MAGDEL		DER		
199. IHFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MRS. MARGARET WEGRZYNIAK 806 S. ROSE STREET BALTO. MD. 21224								
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	a. DUE TO (OR AS DUE TO (OR AS	A CONSEQUENCE OF:	2525 of enter the model	FLEET de of dylng, suc		0., MD	21224 Approximata Interval Betwee Onset and Dec Signal 20 - 40	
PART II. Other significant condition	ona contributing to death i	out not resulting in	the underlying	cause given in				
PART II. Other significant conditions to the condition of	ona contributing to death	but not resulting in		cause given in	PERFOR	AMED?	4b. WERE AUTOPSY FINDING AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 ND	
PART II. Other significant condition	HOSPITAL: 1 Inpatient 2 ER/Out 280. DATE OF INJURY	petient 3 DOA 4	28. PL OTHER: 4 (*) Nursing Homo	ACE OF DEATH (CI	PERFORM 1 YE\$ 2 eck only one) 6 Other (Specify)	AMED?	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Out 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spe	petient 3 DOA 4	28. PL OTHER: 4 Mursing Home OF 28c. INJI WOI 1 U	ACE OF DEATH (C)	PERFOR	NJURY OCCUREO	COMPLETION OF CAUSE OF DEATH? 1 YES 2 ND	



		1 - FOR STATE REGISTRAR	STATE OF MARY		RTMENT OF I		MENTAL HYGIEN		
		DECEDENT'S NAME (First, Middle, Linst)	Dolores :	Ingaberg	Abbott		2. DATE OF OEATH DOWNTH DECEMber	8,1994	
Pin	200	4. SOCIAL SECURITY NUMBER 212-28-3686	1 🗌 M 2 🔀 F	(In yrs. lest birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 11/06/193	30 E	RTHPLACE (State or Foreign buntry) Balto., MD
1, 2, 3 should	TOR	90. FACILITY NAME (If not institution, give st North Arundel Ho RESIDENCE OF DECEDENT				en Burni		Anne Anne	Arundel
Pages	DIRECTOR	Maryland 10b. COUNTY	Baltimore		TY, TOWN OR LOCA		t Howard		10d. INSIDE CITY LIMITS? 1 YES 2 NO
in. ransit permit.	VERAL	7602 Bayside A	venue Box 2	275	10	1. ZIP CODE 21(052		of what country? ed States
5-0020 Inding physician. Is the burial-transit	BY FUNE	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I	2 NO	If yes, sp		NIC ORIGIN? (Specify Yas an, Puerto Rican, etc.) fy:	8	ACE — American Indian, Back, White, atc. pec/ly: WHITE
or afte	LETED	15. DECEDENT'S EOUC (Specify only highest grade Elementery/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life. Do NOT u		ON ost of working		siness/industr	Υ
LAND 2 the hospital e detached fo	COMPL	17. FATHER'S NAME (First, Middle, Last)	1 Year	Mill	Wright	18. MOTHER'S NA	AME (First, Middle, Maiden		тÀ
ned by ould be	H	Kurt Jarmer 19a. INFORMANT'S NAME (Type/Print)		10h MAH ING	Anopess (Street		B. Thiele Route Number, City or Tow		
be retained ge 5 should e notified	2	Wendy McNew			nomas La		mere. Marv		1219
		20e METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remo		Db. PLACE AND DATE	OF DISPOSITION (Na			CATION — City o	
		4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIP	G	len Have	n Cemete			len Bur	nie, MD
SALT r death. re funera al. examir		SACILL	_		Duda- 7922	Wise Av	neral Home	k. Marv	dalk, Inc.
urs a in by		43-PART i. Enter the diseases, or c shock, or heart failure. I	omplications that cause list only one cause on	ed the death. Do each line,	not antar tha mo	ode of dying, suc	ch as cardiac or respi	iratory arrast,	Approximata interval Batween
within 24 I within 24 I opletely fille cremation, rent, the		iMMEDIATE CAUSE (Final disease or condition reaulting in death)	I. CONSIT. DUE TO (OR AS	DULMO!	7944 (PROS			Onset and Death
execute to buria	NOIL	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	MYDCO	padial.	nfaret	7v		Immed
certificate be ding physiciar hygiene prior rother trau	RTIFICATION	cause, Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	(Disease or Injury OUE TO TOR AS A CONSEQUENCE OF):						
T = 5 = 0	CER	resulting in death) CAST							
ORD: that the led by the th and M any inju	MEDICAL	PART II. Other significant conditions	contributing to death	but not reaulting	in the underlyin	g cause givan in	Part I. 24a. WAS AN PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH?
Pen s		DID TODA CCO LICE CONTR	ADUTE TO CALLET			7			1 TES 2 NO
has taw Dept	PHYSICIAN:	DID TOBACCO USE CONTR	IBUTE TO CAUSE C		TH (Check only one)	UNCERTAI	N L L		
VIIA Stan: The rtificate h he State or item	Sic	EXAMINER? 1 ☐ YES 2 X NO	HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/Out	tpatient 3 DOA	OTHER:	ne 5 🗆 Residenca	6 Other (Specify)		
this ce with the	ВУ РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year)		IE OF 28c. INJ		28d. DESCRIBE HOW I	NJURY OCCURED)
DR ATTENDING DIRECTOR: After hours after death tem 28 is ma		3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJUR building, etc. (Spe	Y — At home, farm, eclly)	atreet, factory, offic	•	261. LOCATION (Street a City or Town, State)	and Number or Rui	ral Route Number,
로 크 ~ =	COMPLETED		CIAN: To the best of my known in the basis of examination and the basis of examination in the basis of examination						se(s) and menner as stated,
TO THE HDSPIT TO THE FUNERA be filed within 7	O BE (296. SIGNATURE AND TITLE OF CERTIFIER	Kaplas	mo		29c. LICENSE NUI	MBER COII	29d. DATE SIGN	NED (Month, Day, Your)
		30. NAME AND ADDRESS OF PERSON WHO	15 Opkins	ood KL	#300	6 lent	swenie mi	2100	1
		31. OATE FILED (Month, Day, Year) 12-9-84 DEC 16	32. REGISTRAN 35.0	Dudior	Kardalle				



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DIVISION OF VITAL RECORDS, P.O. BOX 687

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTA CERTIFIC			IENTAL HYGIENE REG. NO.				
7	1. DECEDENT'S NAME (First, Middle, Last) SELENA	Selena Jo	sephine EN	A11	en	2. DATE OF DEATH 1 DAY		3. TIME OF DEATN 5 9 D M		
					IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 11-26-192	8. BIRTI	HPLACE (State or Foreign		
TOR	96. FACILITY NAME (If not institution, give stree St Agnes Hospi RESIDENCE OF DECEDENT	· ·	91	CITY, TOWN OR Baltim	LOCATION OF DEA		n a	DEATH		
DIRECTOR	10e. STATE 10b. COUNTY Maryland na		own or Locatio			10d. INSIDE CITY LIMITS? 1 Xes 2 \(\text{NO} \) NO				
FUNERAL	100. STREET AND NUMBER 926 Popular Gro		I Da.		21216	1	log. CITIZEN OF V	WHAT COUNTRY?		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, speci	IDENT OF HISPANIC Ify Cuben, Mexican, NO Specify:	C ORIGIN? (Specify Yee or Puerio Rican, etc.)	No- 14. RACI Black Speci			
COMPLETED		npleted) College (1-4 or 5+)	16e. DECEDENT'S USI (Give kind of work life. Do NOT use re	done during most tired.)	of working	16b. KIND OF BUSIN		Black		
	17. FATHER'S NAME (First, Middle, Lest)		Domestic		16. MOTHER'S NAM	E (First, Middle, Meiden Su				
TO BE	UNKNOWN 190. INFORMANT'S NAME (Type/Print) James Allen		19b. MAILING AD			ute Number, City or Town, S				
	20a, METNOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Ramova	I from State 20b.	PLACE AND DATE OF D					E.MO, 3/2/6		
	21. SIGNATURE OF FUNETIAL BETWICE LICENS		THUIV	JOSEP	ADDRESS OF EACH	2-19-94 BA	UNERA	L HOME E,MO, 2/223		
	23. PART I, Epish tha diseases, or complete, or heart failure. Lia	I ORIV ORS CSUSS OR SE	ich line	antar tha moda	of dying, such	as cardisc or respirat	ory srrast,	Approximsta		
	disease or condition resulting in death)	malfunction over to con as a	consequence of:	terogr	aft a	orthe and	mitral	1 year		
ATION	Sequantially list conditions, if any, lasding to immediate cause. Enter UNDERLYING									
CERTIFICATION	CAUSE (Disease or injury that initiated events reaulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):							
AL	PART II. Other significant conditions of	ontributing to death bu	ut not reaulting in t	ha underlying o	cause givan in P	art I. 24a. WAS AN AU PERFORME	D?	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE		
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB	UTE TO CAUSE O	F DEATH YES		UNCERTAIN	_		OF DEATH? 1 YES 2 NO		
IVSICI/	1 X YES 2 NO 1	OSPITAL: ER/Outpi	etlent 3 DOA 4	THER: Nursing Nome	5 Residence 6	☐ Other (Specify)				
ву Рн	27. MANNER OF DEATH 1 M. Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	M 1 YES	37 3 2 NO	28d. DESCRIBE NOW INJU				
ETED	3 Suicide 6 Could not be detarmined	28s. PLACE OF INJURY building, etc. (Speci	ify)			281, LOCATION (Street end City or Town, State)		Poute Number,		
COMPLETED	(Check only one) 2 MEDICAL EXAMINER: C							end manner se atated.		
TO BE	296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO CO	MD G	843 Re		9c. LICENSE NUMB		11/	(Month, Day, Year) 30/94.		
	30. NAME AND ADDRESS OF PERSON WNO CO	Co St - Az		ipital	900	Caton Ave,	Bath	n one, MO21229		
	DEC1 6 1994 fel:	Skudsonland	4					DHAM 40 Per 4700		

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

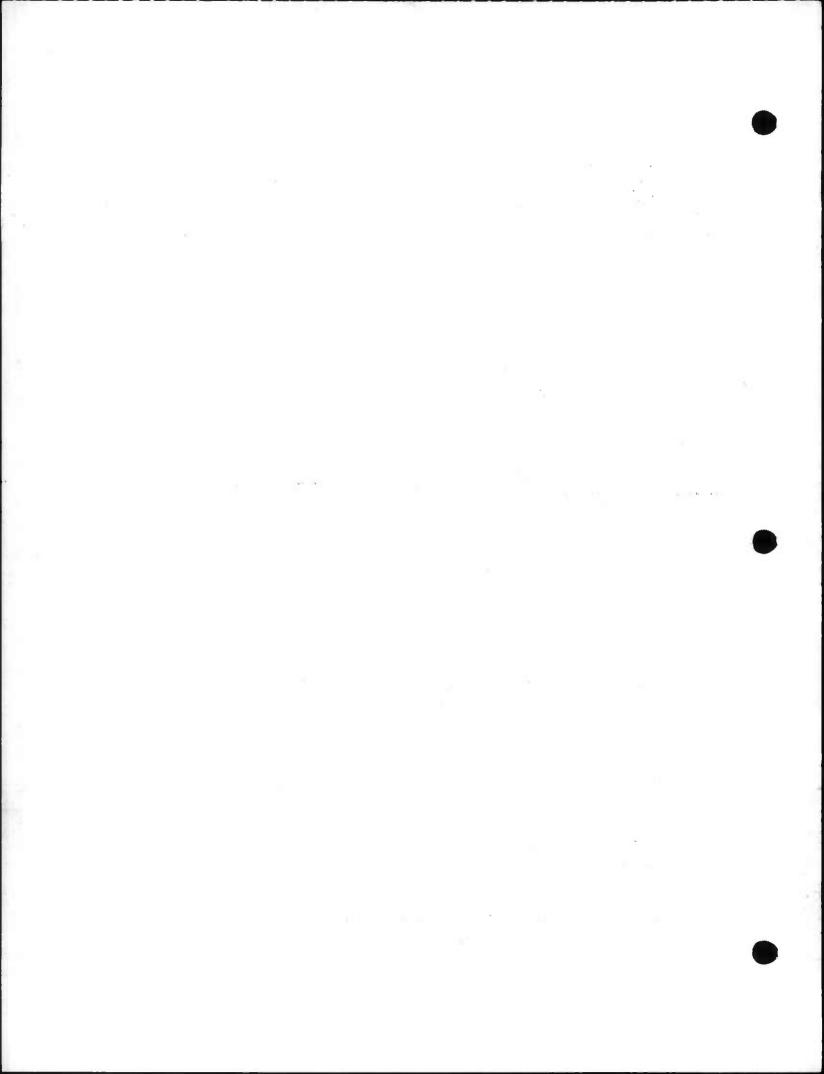
	REGISTRAR		CERTIF	ICALE	F DEATH	REG. NO).			
- 2	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH		
- 3	CARRIE E.	ANDER	SON			MONTH	MY	YEAR O		
								4		
			n yrs. last birthday)	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)		
- 1	1 2 1 00 1 123		9 YRS.	WOMINS DAT	5 HOURS MIN.	Dec. 31	1934	Maryland		
- 8	9a. FACILITY NAME (# not institution, give street	et and number)		9b. CITY, TOV	N OR LOCATION OF I			TY OF DEATH		
Œ	St. Agnes Hosp	ital								
일	Baltimore N/A									
DIRECTOR	10a. STATE 10b. COUNTY		40c CIT	Y, TOWN OR LO	CATION			I and the second second		
<u>~</u>		N/A	100.01					10d, INSIDE CITY LIMITS?		
		IV/ A		Balti	more			XX YES 2 NO		
4	10e. STREET AND NUMBER		N=+ 2T	,	101. ZIP CODE		10g. CITIZ	EN OF WHAT COUNTRY?		
E	709 Nottingham	Road	Apt. 3E	'	21229			USA		
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	II S ADMED	12 446	DECEMBENT OF HIGH	NIC ORIGIN? (Specify Ye	I			
正	1 Never Married 2 Married	FORCES? 1 TYES	2 XNO	If yes	specify Cuben, Maxie	an, Puerto Rican, etc.)	a or No.	14. RACE — American Indian, Black, White, atc.		
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR DA	TES	1 🗆	rES 2 🔀 NO Spec	nly:		specify: Black		
0										
핃	15. DECEDENT'S EDUCAT (Specify only highest grade co	(ION (mpleted)	16a. DECEDENT'S (Give kind of	work done during	ATION most of working	166. KIND OF BL	ISINESS/INDL	STRY		
Щ		College (1-4 or 5+)	life. Do NOT us	se retired.)						
9	5th grade		Cook			-				
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18 MOTHER'S N	AME (First, Middle, Maider	Sumama)			
Ö	James Thomas					e Ghee	ournaine)			
BE										
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stre	et and Number or Rura	Route Number, City or To	vn, State, Zip	21229 e, Maryland		
- 1	Charles N. Ande	rson	709 1	lottin	gham Ro	ad APBalf	imor	e. Marvland		
- 1	20a. METHOD OF DISPOSITION	20b.	PLACE AND DATE	OF DISPOSITION	(Name of	DATE 200.16	CATION - C	Ity or Town State		
	1 Donation 5 Other (Specify)	al from State cem	etery, cremetory or o	ther place)		12/10/92		re, Maryland		
- 1	21. SIGNATURE OF FUNERAL SERVICE LIGEN		oudon F		emetery	Bal	timo	re, Maryland		
	21. SIGNATURE OF PUREFIXE SERVICE LICEN	Jee .		22. NAMI	AND ADDRESS OF F	5240	Reis	terstown Rd.		
	Deray Of	chris		Cha	tman_Ha	rrie F/H	D-1+	imore, Md2121		
	22 DAME LE SALVANO STATE AND AND AND AND AND AND AND AND AND AND									
	23. PART I: Enter the diseases, or cor shock, or heart fellure. Lie	nplicetione that caused at only one cause on a	the deeth, Do r ich iine.	not enter the	mode ot dying, au	ch as cardlec or reep	iretory arre			
	IMMEDIATE CAUSE (Final									
1	disease or condition Ac. to Pin Down on the Pin Down of the Pi									
1	resulting In deeth) e. There is a consequence op.									
	C. A TO A CONSEQUENCE OF):									
8	disease or condition resulting in deeth) e. Acute Pulmonary Edema 2 days Due to (or as a consequence of): Coronary Artry Disease (severe diffuse 3 versel disease) 1 yr But to (or as a consequence of): Due to (or as a consequence of):									
Ĕ	The state of the s									
2	CAUSE (Disease or Injury							l .		
E	thet initieted eventa	DUE TO (OR AS A	CONSEQUENCE OF	F):						
E	resulting in death) LAST							ļ		
CERTIFICATION										
	PART II. Other significent conditions	contributing to death be	at not resulting	In the underly	ing cause given is	Pert I. 24s. WAS AI		24b. WERE AUTOPSY FINDINGS		
DICAL	Hyperleusion, Ins	Dir desperd	out di	10000	us PD. Fila	PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE		
<u> </u>	H	1/ /2	200				2 DNO	DF DEATH?		
ME	ctironic renal for	elevel, lepter	uller, a	anolide	Artery Stew	Erus		1 TYES 2 NO		
	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF	DEATH YE	S NO	☐ UNCERTA	NZ				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL		8. PLACE OF DEAT							
S	EXAMINER?	IQSPITAL:		OTHER:						
₹		10 Inpatient 2 ER/Outp			Iome 5 Residence					
F	27. MANNER OF DEATH	26a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c.	INJURY AT WORK?	26d. DESCRIBE HOW	INJURY OCC	JRED		
	-			M 1 [YES 2 NO					
≿ I	1 Natural 6 Pending		PLACE OF INJURY At home, farm, street, factory, office		ffice					
р Вү	1 Natural 6 Pending 2 Accident Investigation	26s. PLACE OF INJURY	At home, farm, s	street, factory, office 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				r Rural Route Number,		
	1 Natural 6 Pending 2 Accident Investigation	26s. PLACE OF INJURY building, atc. (Speci	At home, farm, s	street, factory, c	11102			r Rural Route Number,		
	1 Netural 6 Pending 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide datarmined	building, atc. (Speci	fy)			City or Town, Statu)			
	1 Netural 6 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only) 1 CERTIFYING PHYSICIA	AN: To the best of my knowle	edge, daath occurn	ed at the time, o	lete and place, and du	City or Town, State	nner as atate	d.		
	1 Netural 6 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only) 1 CERTIFYING PHYSICIA	AN: To the best of my knowle	edge, daath occurn	ed at the time, o	lete and place, and du	City or Town, State	nner as atate	d.		
COMPLETED	1 Natural 6 Pending Investigation 3 Suicide 8 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	AN: To the best of my knowle	edge, daath occurn	ed at the time, o	late and place, and du	a to the cause(a) and ma	nner as atate	d. cause(a) and manner as stated.		
E COMPLETED	1 Netural 6 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only) 1 CERTIFYING PHYSICIA	NN: To the best of my knowle	edge, death occurre and/or investigation	ed at the time, o	lete and place, and du n, death occured at th 29c. LICENSE NU	a to the cause(a) and mae time, data and placa, a	nner as atate nd due to the 29d. DATE	d. cause(a) and manner as stated. SIGNED (Month, Day, Year)		
BE COMPLETED	1 Netural 6 Pending Investigation 3 Suicide 8 Could not be datermined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	N: To the best of my knowledge on the basis of examination	edge, death occum and/or investigatio	ed at the time, on, in my opinio	lete and place, and du n, death occured at th 29c. LICENSE NU	a to the cause(a) and ma	nner as atate nd due to the 29d. DATE	d. cause(a) and manner as stated.		
E COMPLETED	1 Natural 6 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only only 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	N: To the best of my knowledge of axaminstion Residue of Completed Cause of DEA	and/or investigatio	ed at the time, on, in my opinio	lete and place, and du n, death occured at th 29c. LICENSE NL D = 444	city or Yown, State a to the ceuse(a) and ma e time, deta and placa, a IMBER	nner as atate and due to the	d. cause(a) and manner as stated. SIGNED (Month, Day, Year)		
BE COMPLETED	1 Natural 6 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only only 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	N: To the best of my knowledge of axaminstion Residue of Completed Cause of DEA	and/or investigatio	ed at the time, on, in my opinio	lete and place, and du n, death occured at th 29c. LICENSE NL D = 444	city or Yown, State a to the ceuse(a) and ma e time, deta and placa, a IMBER	nner as atate and due to the	d. cause(a) and manner as stated. SIGNED (Month, Day, Year)		
BE COMPLETED	1 Natural 6 Pending Investigation 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER COLUMN SIGNATURE AND ADDRESS OF PERSON WHO COLUMN SIGNATURE SIGN	N: To the best of my knowledge of examination on the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis of examination of the basis	and/or investigation Level TH (ITEM 27) (Type,	ed at the time, on, in my opinio	lete and place, and du n, death occured at th 29c. LICENSE NL D = 444	city or Yown, State a to the ceuse(a) and ma e time, deta and placa, a IMBER	nner as atate and due to the	d. cause(a) and manner as stated. SIGNED (Month, Day, Year)		
BE COMPLETED	1 Natural 6 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only only 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	N: To the best of my knowledge of axaminstion Residue of Completed Cause of DEA	and/or investigation Level TH (ITEM 27) (Type,	ed at the time, on, in my opinio	lete and place, and du n, death occured at th 29c. LICENSE NL D = 444	city or Yown, State a to the ceuse(a) and ma e time, deta and placa, a IMBER	nner as atate and due to the	d. cause(a) and manner as stated. SIGNED (Month, Day, Year)		

ermit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within nous after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit p be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
The law requires that the death certificate be executed within	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL DR ATTENDING PHYSICIAN:	TO THE FUNERAL DIRECTOR; After this certifica be filed within 72 hours after death with the St.	IMPORTANT: If Item 28 is marked, or it

	1 - FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTM CERTIFICA			MENTAL HYGIEN				
1	1. DECEDENT'S NAME (First, Middle, Lest)			-		2. DATE OF DEATH		3. TIME OF DEATH		
	Mary Arrin	gton				December	10.	1994 7:45 PM		
				UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BURTH		BIRTHPLACE (State or Foreign Country)		
	241-10-0401	$241-16-8481$ $^{1}\square$ M $^{2}\square$ F 7 7 YRS 1								
DIRECTOR	9a. FACILITY NAME (# not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH MARYLAND GENERAL HSP. BALTO. CITY									
ᇤ	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY	10d, INSIDE CITY								
E I	MD. 106. CITY, TOWN OR LOCATION BALTIMORE CITY							LIMITS?		
	10e. STREET AND NUMBER		DALL		. ZIP CODE		10g. CITIZEN OF WHAT CO			
ER/	2505 AIRDA	LE AVENUE		2	1217		USA			
FUNERAL		12. WAS DECEDENT EVER IN	U.S. ARMED			IIC ORIGIN? (Specify Ye	I. RACE — American Indian,			
	1 Never Married 2 Married	FORCES? 1 YES			2 X NO Specify	n, Puerto Ricen, etc.)	Black, White, etc.			
ВУ	3 X Widowed 4 Divorced				4			BLACK		
COMPLETED	15. DECEDENT'S EDUCA (Specify only highest grade co	TION ompleted)	18a. DECEDENT'S USU. (Give kind of work of	done durina mo	ON st of working	18b. KIND OF BU	SINESS/INDUS	STRY		
<u>ا</u> و	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use reti	ired.)						
₽ I		NKNOMN	COOK							
	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maider	Surname)	- 1		
8	GRANT ARRINGTO					KNOWN				
2			1		ND AVE.	BALTO.		ode)		
	CHELSEA BATTY 200. METHOD OF DISPOSITION	000.4	PLACE AND DATE OF DIS					TO SECURE		
	1 XBuriel 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	al from State came:	tery, crematory or other p	elace)	re or	1		y or Town, State		
1	21. SIGNATURE OF FUNERAL SERVICE LICES		I. ZIUN		D ADDRESS OF FAC		топпт	NO PERKI KD.		
- 1	· / /	161.116	11							
-	Music	arrow	N	1712	W. NORTH	H AVE. B	ALTO.	MD. 21217		
	23. PART I. Enter the diseases, or conshock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death)	st only one csuee on eac	ch lina. e Myelorii consequence of):		ou or dying, such	r as calured of reap	netory sires	t, Approximate Interval Batween Onset and Death		
CERTIFICATION	Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST									
S	d.									
PHYSICIAN: MEDICAL	PART II. Other significant conditiona Pneumonia, Hype					PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
ME	Pulmonary Dise	ase, Hypot	hyroidis	m			-X	1 YES 2 NO		
ž	DID TOBACCO USE CONTRI				UNCERTAIN	1				
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		B. PLACE OF DEATH (C							
Sic	The state of the s	HOSPITAL:		HER: Nursing Hom	5 Residence	6 Other (Specify)				
H	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJ	JRY AT RK?	26d. DESCRIBE HOW	NJURY OCCUP	RED		
BY	1 Natural 5 Pending 2 Accident Investigation				ES 2 NO					
B	3 Suicide 8 Could not be datarminad	28a. PLACE OF INJURY – building, atc. (Specify	At home, larm, street	, factory, office		281. LOCATION (Street City or Town, State,	and Number or	Rural Route Number,		
COMPLET		AN: To the best of my knowled								
ō I		On the besis of examination is	and/or investigation, in	my opinion, d	ath occured at the	time, data and place, ar	d due to the c	ause(s) and manner as atsted.		
BE	296. SURFLY VIEW AND TITLE OF CENTIESES				29c. LICENSE NUM	BER	29d. DATE S	IGNED (Month, Day, Year)		
ρ Ε	stally nell	w					Dec	ombor 11 100		
- 1	60. NAME AND ADDRING OF PERSON WHO					-				
	Dr. Harry Harri	s C/O Mary	Land Gen	eral	Hospit	al				
	31. DATE FILES (1076 0 1994 Jul	32 DEGISTRAR'S PONN	all.							



1 - FOR STATE REGISTRAR

												***	-a. No.				
		1. DECEDENT'S NAME (First, Middle, List) 2. DATE OF DEATH MONTH DAY YEAR								. TIME OF DE							
							artner				Dec. 8 1994 1:27 P				P		
		4. SOCIAL SECURITY NUMB	ER	5. SEX	6. AGE (II	n yrs. last	birthday)	IF UNDER		IF UNDE	R 24 HRS.	7. DATE OF B (Month, Day	IRTH (Mar)		8. BIRTHPI Country)	ACE (State or	Foreign
P			216-46-8185 1 □ M 2 💢 F 91			1	YRS.	RS. MONTHS DAYS HOURS MI			BHIN.	Aug.	12	1903		yland	
2, 3 should		9a. FACILITY NAME (If not in:						9b. CITY, TOWN OR LOCATION O			ION OF DE	ATH	9c. COUNTY OF OEATH				
	6	Greater Baltimore Med. Ctr.						To	NSOI	n			Balto.				
←*	딦	10a. STATE	10b. COUNTY				10c. CIT	Y, TOWN (OR LOCA	TION					Τ,	NSIDE CI	TV
Ba	DIRECTOR	Maryland	Balti	more				hoen								Dd. INSIDE CI LIMITS? YES 2 [
permit. Pages	AL (10e. STREET AND NUMBER	Durei	11101 C			•			H. ZIP COD	E			10a, CITI		AT COUNTRY	
is.	ER/	14110	larrett	tsville Pi	ke					21	131				JSA		•
physician. burial-transit	FUNER	11. MARITAL STATUS		12. WAS DECEDEN	NT EVER IN	U.S. ARA	IED	13.	WAS DE	CENDENT (OF HISPAN	IIC ORIGIN? (Sp	ecify Yea		14. RACE -	- American In	dlen.
al or attending for use as the	TO BE COMPLETED BY	1 Never Married 2		FORCES?			0			pecify Cubi		n, Puarto Rican,	atc.)		Black, Specify:	White, etc.	_
		3 Widowed 4 Divorced													Whit	e	
		(Specify only highest grade completed)				(Giv	Ba. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KINI	16b. KIND OF BUSINESS/INDUSTRY					
		Elementary/Secondary (0-	-12)		College (1-4 or 5+) 2 House								Own Home			16	
he hospit detached once.		17. FATHER'S NAME (First, MI	Iddle (ast)		Housewii			VIIC				AND ADDRESS AND AD	(First, Middle, Maiden Surname)				_
nours after death. Page 6 may be retained by the din by the funeral director, page 5 should be det or removal. medical examiner must be notified at on		Henry Bucksbaum Buchsbau				aum	4.00					Miller	, Maiden :	surname)			
		19a. INFORMANT'S NAME (7)		, baaiii		19b.	MAILING	ADDRESS	S (Street		<u> </u>	Route Number, Ci	ty or Town	State Zin	Code)	21811	
		Mary L	ee Fe	ilinger								Morning					ИD
		20a. METHOD OF DISPOSITI	ON		20ь.	PLACE A	ND DATE (OF DISPOS	ITION (N	eme of		DATE	20c. LOC		City or Town		
		1 XBurlel 2 Cremation 3 Ramoval from State Cemetery, crematory or other piece St. John's Luth. Ch. Cem. 12/10 Jarrettsville, MD)					
	1	22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home															
	4	Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093										93					
		23. PART I. Entar the disesses, or complicatione that caused the daeth. Do not entar the mode of dying, such as cardiac or respiratory arrest, Approximate															
		ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Dae															
		disease or condition resulting in death)															
	NO			DUE TO	(OR AS A	CONSEC	UENCE OI	7):			7						
executed and com o burial,		Sequentially list conditions,															
8 0 5	Ĕ	If any, leading to immediate couse. Enter UNDERLYING															
physician ne prior to	일	CAUSE (Disease or Injury									-						
ding dygie	CERTIFICATION	that initisted events resulting in death) LAST															
ne death c the attend Mental Hy ijury, or	E	PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDING															
at the interest of the second	뒿	PART ii. Other algnificat	nt condition	s contributing to	daath bu	it not ra	suiting i	n tha ur	deriyin	g cause	givan in	Part i. 24a.	WAS AN A			ERE AUTOPSY	
5 D = 5	MEDICAL	1 YES 2 NO								OMPLETION DI							
een signe of Healt									_	,		_	/		1	YES 2] NO
as bept.	ä	DID TOBACCO US		RIBUTE TO CA	_				10 P		ERTAIN	<u>ا 🗆 ۱</u>					
SICIAN: The last certificate has the State Deg 1, or item 23	PHYSICIAN:	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:				H (Check									
ICIAN ertific the S	17S	1 YES 2 NO		1 Nopetlant 2		rtlant 3 (asidence	8 Other (Spe					
PHY this with		27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? M 1 YES 2 NO															
After death s mai	BY	2 Suitalda	nvestigation	26a. PLACE C	OF INJURY	— At horr	e, ferm, s	1 123 1 10				281. LOCATION (Street and Number or Rural Route Number,					
TTEN TOR: after		3 Suicide 6 Could not be determined 25e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 281. LOCATION (Street and Number of City or Town, State)							or + 101 iii 1 100	to mornou,							
OR ATTENDING DIRECTOR: After hours after death item 28 is ma	COMPLETED	29a. CERTIFIER 1 CERTI	FYING PHYSI	CIAN: To the best of	my linnada	other days	th accurre	d at the t	lma data	and also							
로 크 ~ =	M.			R: On the basis of												nd menner es	stated
TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If		29b. SIGNATURE AND TITLE			-/	0					ENSE NUM						
THE field	BE	(Yan	w	X	265	7				7	CV	WIDER 29d. DATE			E SIGNED (Month, Day, Year)		
는 는 정 중	5	30. NAME AND ADDRESS OF	PERSON WHO	O COMPLETED CAU	SE OF DEA	TH (ITEM	27) (Type.	Print)		リン・	77	01			¥-7	-74	
		Paul M. Rivas, M.D. 3421 Sweet Air Rd., Phoenix, MD 21131															
		31. DATE FILED (Month, Day,)	bar)	Jalia d	R'S SIGNA	TURP	1.11	, ,, ,,	CEL	All	NU.	- FIIOE	шX,	IVID			
		DEC 16	1994	Java	WATER COMMISSION OF THE PARTY O	K I VOICE	plant,										

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

.

9c. COUNTY OF DEATH

Baltimore

USA

Utah

10g. CITIZEN OF WHAT COUNTRY?

White

3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 YES 2 NO

8. BIRTHPLACE (State or Foreign

Item# 15. G-film 718 per F.H 12/16/94 P.C

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO. CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Coral Gordon Bolin Dec. 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH DAYS HOURS 220-52-3322 1 M 2 7 F 89 YRS. 10/12/1905 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATN DIRECTOR 2122 Pot Spring Rd. Timonium, MD RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION Baltimore Timonium permit. 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE hours after death. Page 6 may be retained by the hospital or attending physician, ed in by the funeral director, page 5 should be detached for use as the burial-transit 2122 Pot Spring Road 21093 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-**MARYLAND 21215-0020** If yes, specify Cuben, Mexican, Puerto Ri
1 ☐ YES 2 ☒ NO Specify: 1 Never Married 2 Merried IF YES, GIVE WAR OR DATES BY 3 🔀 Widowed 4 🗌 Divorced for use as the ED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRO during most of working COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 10 5+ 12 Physician Medical 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) te Foster John Gordon BE Isabel Miriam Meikle notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Coral B. Crosby Rt. 3, Box 281-12 - Charlottesville, VA 22903 BALTIMORE, pe 20e. METHOD OF DISPOSITION
1 X Buriel 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must 4 Donation 5 Other (Specify) Baltimore National Cem. 12/19/94 Baltimore, MD 21. SIGNATURE OF CUNERAL BERVICE LICENSES examiner 22. NAME AND ADDRESS OF FACILITY Blyn W. Clary Lemmon Funeral Home 10 W. Padonia Rd. Timonium, MD 21093 and completely filled in by the to burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart fellure. List only one ceuse on each line. IMMEDIATE CAUSE (Final the disease pr condition requires that the death certificate be executed within event, resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760, arteriosdewsis traumatic CERTIFICATION Sequentially liet conditiona, prior to If any, leading to immediate the attending physician Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease Dr Injury Injury, or other DUE TO (OR AS A CONSEQUENCE OF) that initiated evente reaulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceues given in Pert I. MEDICAL 24s. WAS AN AUTOPSY has been signed by t Dept. of Health and PERFORMED shows any 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: UNCERTAIN OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) this certificate his with the State [1 YES 2 NO OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 - Nursing Home 5 Chaeldence 6 - Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 28d. DESCRIBE NOW INJURY OCCURED Natural. 5 Pending M 1 YES 2 NO B death DIRECTOR: After 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 90 8 Could not be COMPLETED after 28 4 Nomicide determined TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT DE filed within 72 hours at MPORTANT: If Item 2 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end placa, and due to the cause(s) and menner as stated. (Check only one) 2 MEDICAL EXAMINER: On the beals of exemination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(a) end menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 1950

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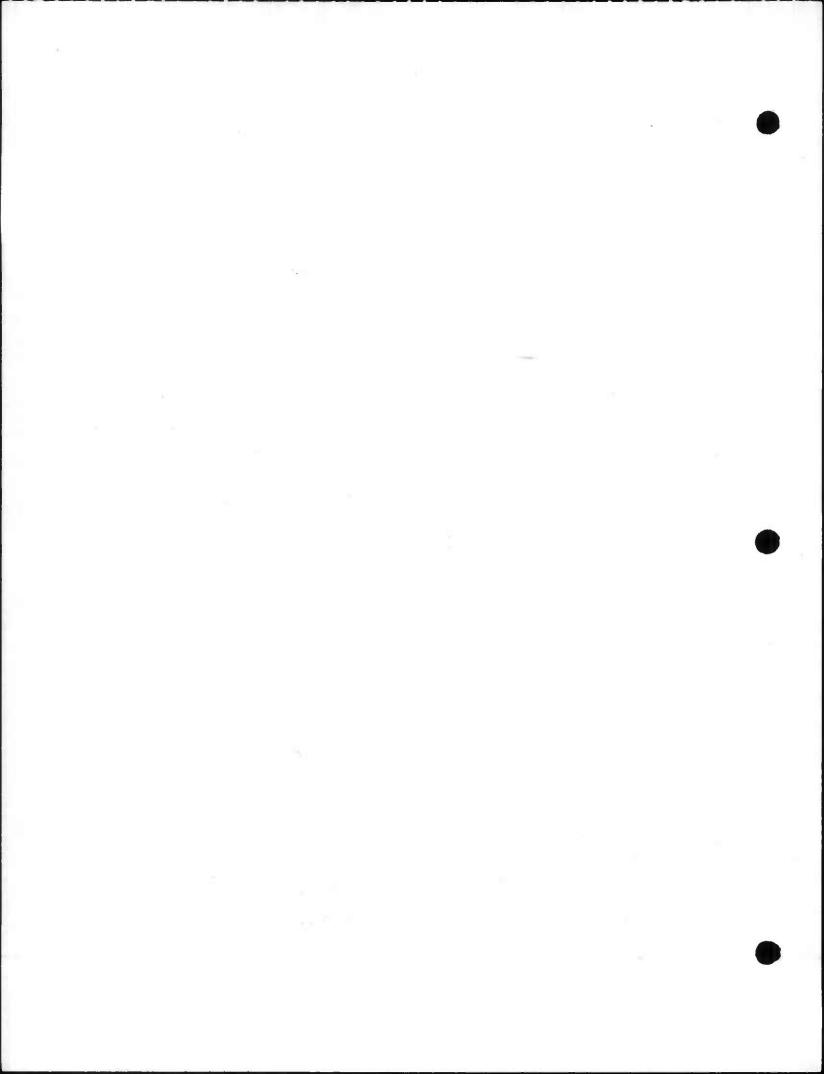
32. REGISTRAR'S STRINATURE

Edward Costlow, MD - 10 Gerard Ave., Timonium, MD 21093

30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

20c. LOCATION — City or Town, State Approximate Interval Between **Onset and Dasth** < /WX 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29d. DATE SIGNED (Month, Day, Year) 6-DHMH-18 Rev 1/89





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215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

ENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	R. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3	er death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
E HOSPITAL OR ATTENDING PHYSICIAN: T	E FUNERAL DIRECTOR: After this certificate	s within 72 hours after death with the Stat	RTANT: If Item 28 Is marked, or Ite	
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law	TO THE FUNERAL DIRECTOR: After this certificate has b	be filed within 72 hours after death with the State Dept.	MPORTANT: If item 28 is marked, or item 23	

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3 PERSTANDED TO PROPERTY PROPE

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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH RUTH WORKMAN BALDWIN. MD 1994 DECEMBER 13 16:00 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) 6. BIRTHPLACE (State or Foreign Country) # UNDER 1 YEAR # UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) DAYS 1 🗌 M 2 🙀 F HOURS YRS. 332-10-3639 79 November 3 Illinois Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATI DIRECTOR St. Agnes Hospital Baltimore 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Md. Baltimore 1 YES 2 NO FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 324 Gun Road 21227 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married
3 Divorced If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: BY Specify: white COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) 8+ Doctor Jniv. of Md. Medical Center 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) lohn Workman BE Lucielle Haves 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Gary M. Baldwin <u>324 Gun Road, Balto..</u> 21227 Md. 20s. METHOD OF DISPOSITION
1 Buriel 2 Cremetion 3 Removal from State
4 Denetion S Disposity) 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE 12/15 Baltimore. Md Mount Cemetery 21. SIGNATURE OF PUNERAL SERVICE LICENSEE, FACILITY Gary L. Kaufman Funeral Home of Elk., Inc. 5695 Main St., Elkridge, Md. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or reepiratory streat, shock, or heart failure. List only one cause on each line. Approximate Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in desth) MYOCANDIA INFARCTION 2 HAS DUE TO (OR AS A CONSEQUENCE OF): Anten 10 YRS ORONANY CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST PART II. Other eignificent conditions contributing to deeth but not reculting in the underlying ceues given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO PARKINSOM'S DISOASE COMPLETION OF CAUSE 1 | YES 2 NO OF DEATH? CEREBROVASCULAN ACCIDENTS 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER?
1 YES 2 NO 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER: ne 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be determined 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIONATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIONED (Month, Day, Year) BE S. 7. itt mo 194 D36748 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

900 CATON AVE.

BACTO.

MD

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Day, Year)
DEC 16 1994

	Technio 12	10-74 11	11110710	W . II	rer i	. / 11					74	J	1200		
	1 - FOR STATE REGISTRAR	STATE OF M	MARYLAND /				EALTH DEAT		MENTAL	HYGIEN REG. NO	_				
	1. DECEDENT'S NAME (First, Middle, Last)					_			2. DATE O	F DEATH			3. TIME OF DEA	ГН	
	MAURICE L. BOO	KER							DEC	_	3	9 4	8:47P	М	
	4. SOCIAL SECURITY NUMBER	5. SEX 8. AGE (In yrs. last birthday) IF UNDER			1 YEAR	IF UNDER	24 HRS.	7. DATE OF BIRTH 8.		8. BIRTI	IPLACE (State or Fi	oreign			
	216-90-7075	1 □ M 2 □ F	20	YRS.	MONTHS	DAYS	HOURS	MIN.	Dec 6	Day, Year)	74	Count	7d		
	9e. FACILITY NAME (If not institution, give s				TOWN C	OR LOCATION OF DEATH			9c. COUNTY OF D						
TOR	4700 BLOCK O						MORE CITY								
DIRECTOR	100. STATE 100. COUNTY	, 10			alto								10d, INSIDE CITY V LIMITS? 1 1 YES 2		
FUNERAL	10e, STREET AND NUMBER					10f. ZIP CODE				-	10g. CI	TIZEN OF	WHAT COUNTRY?		
EB	3602 Callaway	Avenue			21215			215				J S A			
S	11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED			13. WAS DECENDENT OF HISPA				NIC ORIGIN? (Specify Yes or I			No. 14 RACE - American India			
BY F	1 Never Married 2 Merried 3 Widowed 4 Divorced		FORCES? 1 YES 2 NO If y				2 NO	n, Mexica	ngPuerlo Ric	ean, etc.)	Black, White, etc. Specify: Blac			,	
0	15. DECEDENT'S EDU		18a. DF	CEDENT'S	LISUAL O	CCUPATIO	M.		165.0	IND OF BU	CINECO (IA	DUETOV	DIACK	_	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12) 12th					during most of working			100.7	and or bo	3114233711	DOSINI			
₩.	17. FATHER'S NAME (First, Middle, Last)			TIOWIT											
							18. MOTH	nice	ME (First, Mic		,				
BE	Luvell K. Booke	r					9.9	ncte		Wil					
2	19e. INFORMANT'S NAME (Type/Print)		191	. MAILING	ADDRESS	S (Street a	nd Number	or Rural I	Route Number	City or Tow	rn, State, 2	(ip Code)			
	Janice E. Booke	r	3	602	Call	away	Ave	nue	Balto	. Md	212	15			
	20e. METNOD OF DISPOSITION 1) X Burlet 2 Cremetion 3 Rem	ovel from State	20b. PLACE	NDDATE	OF DISPOS				DATE			- City or To	own, State		
	4 Donation 5 Other (Specify)	State Irom State	cemetery, cre	oshe		N Me	mori	al	12198	Ra Ba	1to	Md			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE														
	March F/H West 4300 Wabash Avenue Balto, Md 21215														
	23. PART I. Enter the diseases, or o	omplications that	t ceused the de	ath. Do	not enter	the mo	de of dyi	ng, auc	h aa cardie	c or reap	iratory a	rrest,	Approxim	ale	
	shock, or heert failure. List only one cause on each line. Interval E IMMEDIATE CAUSE (Finel														
- !		MILLE	TRUE C.	CAUCE	LOT 1	110	n . «Λ						1	2 0 0 0 0 1 1	
	disease or condition resulting in death) Out TO (OR AS A CONSEQUENCE OF):														
_	DOE TO (ON AS A CONSCOURNCE OF):														
ERTIFICATION	Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF):														
F	if any, leading to immediate cause. Enter UNDERLYING									i					
윤	CAUSE (Disease or Injury	C. DUE TO	(OR AS A CONSEC	HENCE O	D.										
Ē	that initiated events reaulting in death) LAST	502.10	(ON AS A CONSEC	OENCE O	r).								i		
	d														
2	PART II. Other significent condition	s contributing to	desth but not re	esulting	in the un	derivino	csuse 0	lven in	Part I. 2	4a. WAS AN	AUTOPSY	246	. WERE AUTOPSY F	INDINGS	
8		_								PERFO	RMED?		AMAILABLE PRIOR	TO	
			-					_	1	YES :	NO NO		OF DEATN?	3-10 GE	
PHYSICIAN: MEDICAL													1 YE\$ 2	NO	
ž	DID TOBACCO USE CONTI	RIBUTE TO CA					UNC	ERTAIN	N 🗆						
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLAC	E OF DEA	TN (Check		-								
S	MOSPITAL: 1 I Inpetient 2 ER/Outpetient 3 DOA IN CAR ON								ON STRE	ET					
H	27. MANNER OF DEATH 280. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED														
ВУ	1 Netural 5 Pending 2 Accident Investigation	12.13					YES 2 NO ST			MISUT SHOT					
	3 Suicide 8 Could not be	28e. PLACE O	28e. PLACE OF INJURY At home, term, street, factory, office				281. LOCATION (Street and Number or Rural Route Nu			Route Number,					
	4 Homicide determined	(AR	etc. (Specify)		THE	-			LI TANK	Town, State				10	
9	29e. CERTIFIER		OLTH						71001	DEDUR			שאושון שנב	740	
COMPLET	(Check only 1 CERTIFYING PNYS)	CIAN: To the beet of													
Ö	one) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
ш	29b. MENATURE AND TITLE OF CERTIFIER	(11)					29c. LICE	NSE NUM	MBER		29d. DA	TE SIGNED	(Month, Day, Yeer)		
@	Waller is ho	74,10	/				0.0	M	1.E. DEC. 14/94						
2	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	SE OF DEATN (ITER	A 27) (Type	. Print)		J. C	. 11				10.	C. 14/J4		
	MAMPHON A WARGUWIII Penn Street, Baltimore, Maryland									cyla	nd 2	21201			

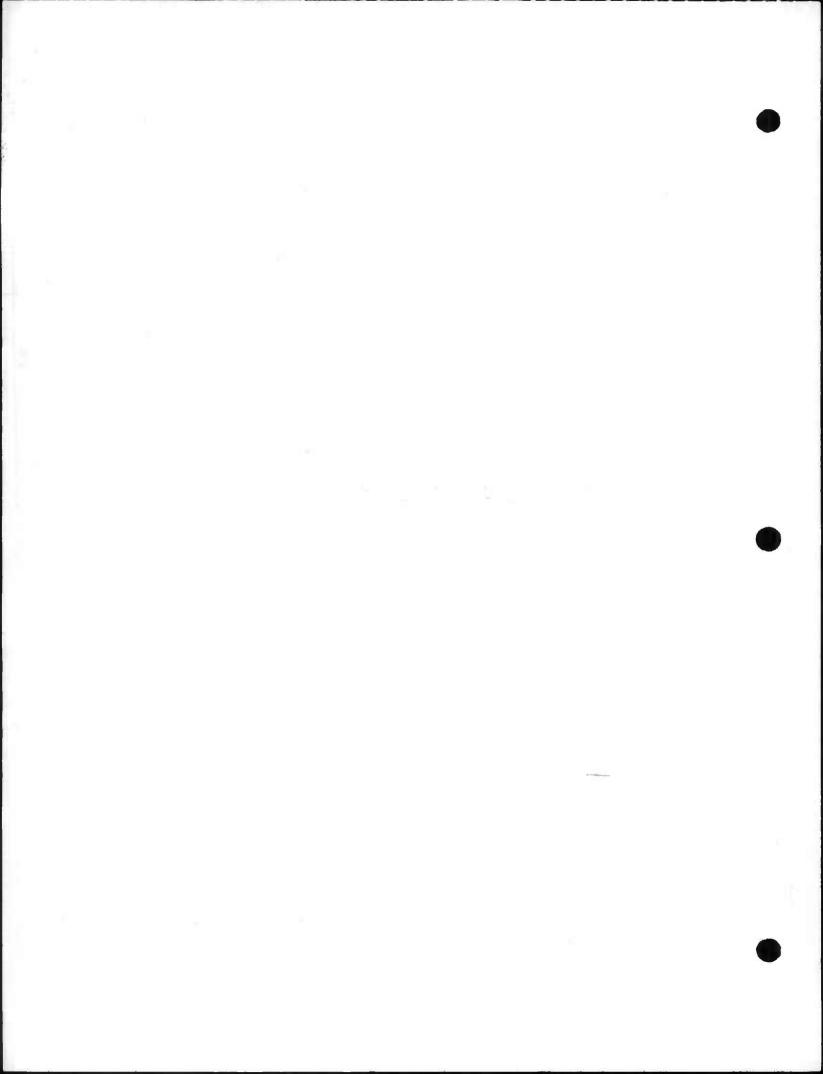
		1 - STATE REGISTRAR	STATE OF MARY		RTMENT OF I		MENTAL HYGIEI REG. NO				
		1. DECEDENT'S NAME (First, Middle, Last) Carmine JOSEPH	Joseph		Ва	rile			3. TIME OF DEATH 94 10:31 A.		
I. 2. 3 should		4. SOCIAL SECURITY NUMBER 158-18-8097	5. SEX	E (In yrs. last birtnday) YRS.	IF UNDER 1 YEAR MONTHS DAYS		7. DATE OF BIRTH (Month, 1 (Year) July 20,		BIRTNPLACE (State or Foreign Country) N.J.		
	OR	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH									
- S	<u> </u>	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Y	10c. CI	Y, TOWN OR LOCA	TION			10d. INSIDE CITY		
permit. Pages	DIRECTOR	Md.			Baltimo	ore			LIMITS?		
	RAL	10e. STREET AND NUMBER 4 Paca St.			10	21201			N OF WHAT COUNTRY?		
020 physician. burial-transit	FUNER	11. MARITAL STATUS	12. WAS DECEDENT EVER	R IN U.S. ARMEO	13. WAS DE		NIC ORIGIN? (Specify Yo	-	J.S.A.		
IMORE, MARYLAND 21215-01 Page 6 may be retained by the hospital or attending I director, page 5 should be detached for use as the ner must be notified at once.	В	1 🔀 Never Married 2 Married 3 Wildowed 4 Divorced	FORCES? 1 YE			pecify Cuban, Maxica 5 2X NO Specify	n, Puerlo Rican, atc.)	o Rican, atc.) Black, White Specify: W			
	ETED	15. DECEDENT'S EDU (Specify only highest grade		(Give kind of	USUAL OCCUPATI	ON ost of working	16b. KIND OF BI	16b. KIND OF BUSINESS/INDUSTRY			
	PLE	Elamentary/Secondary (0-12)	College (1-4 or 5 +)	Mainte	nance Ma	an	Marulan	Maruland Square P			
	COMPL	17. FATNER'S NAME (First, Middle, Last)	D.	rile	mance He	1		Maryland Square Res ME (First, Middle, Maiden Surname)			
	ш	Fredinando		rile		Santa		Tolomeo			
	TO B	19a. INFORMANT'S NAME (Type/Print)						er, City or Town, State, Zip Code)			
		Mr. George Anigna	·				rry Hall,				
		20e, METNOD OF DISPOSITION 1 (X Surial 2 Cremation 3 Removal from State Cemetery, cremetory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery cremetory or other place) 3 Removal from State Cremetory or other place) Greek Orthodox Cemetery 12/16 /94 Baltimore, Md.									
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY									
9 3 9		Ruck Towson Funeral Home Inc. 1050 York Rd. Towson, Md. 21204 23. PART I. Enter the diseases, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
P.O. BOX 68760 th certificate be executed within 24 hours aft pending physician and completely filled in by I Hygiene prior to burial. cremation, or remo or other traumatic event, the medical	N	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a Arteriosclerotic Cardiovascular Disease OUE TO (OR AS A CONSEQUENCE OF):									
	CERTIFICATION	if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
RECORDS, requires that the dea been signed by the att t. of Heafth and Menta shows any Injury,	MEDICAL	PART II. Other algolificant condition	s contributing to death	but not reaulting	in tha underlyin	g cauaa givan in	Part I. 24s, WAS AI PERFO	RMED?	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO		
law re as bee Dept. o		DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH Y	ES 🗌 NO 🗆	UNCERTAIN	V 🗆				
TA The The steep that the steep that	SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	28. PLACE OF OEA	OTHER:	ne 5 🗆 Rasidence	6 Other (Specify)				
	РНҮ	27. MANNER OF DEATN XX Natural 5 Pending	28a. DATE OF INJURY (Month, Day, Year,		JURY WO	JURY AT DRK? YES 2 NO	28d. OEŞCRIBE NOW	INJURY OCCUP	REO		
ISION FTENOING TOR: After after death 28 is ma	ETED BY	2 Accident investigation 3 Suicide 8 Could not be 4 Nomicide detarmined	28s. PLACE OF INJUI building, stc. (Sp			281. LOCATION (Street City or Town, State	CATION (Street and Number or Rural Route Number, y or Town, State)				
₹ 4 % =	COMPLE	Tithel	CIAN: To the best of my kno						ause(s) and manner as stated.		
HOSPI FUNEF Within	- 14	296. AICH TURE AND TITLE OF CERTIFIE		\		29c. LICENSE NUM			IGNED (Month, Day, Year)		
TO THE HOSPI TO THE FUNER be filed within	TO BE	llarn	nlew)		O.C.M.			EC 13,1994		
		J. LARON LOCKE N				reet R	altimore	Marr	yland 21201		
		31. DATE FILES (Mentils Company)	22. REGISTRAR'S SIG		CIII BU	LCCL, DO	TITILITE	, riar	A TOUR 51501		

II la •

BALTIMORE, MARYLAND 21215-0020

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1994AR DEC. 04 BELL 8:06 DANIEL R. Α 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birtnday) 5 SEX TE OF L. South, Day, You, 20 IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign DAYS 43 1 M 2 F Jan. 1951Maryland permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 316 N.PACA STREET BALTIMORE RESIDENCE OF DECEDENT 10a STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Mareland Baltimore 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 316 N. Paca St. Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-transit i 21201 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. RACE - American Indian, Black, White, stc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried 1 TYES 2 NO Specify: ВY Specify: 3 Widowed 4 Divorced Black C 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g Щ Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Roofer Roofing once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Daniel Bell Sr. ē Lucy E. Coles BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Gode) 2 Lucy E. Bell 2640 Cecil Ave. Balto. Md. 21218 be 20e. METHOD OF DISPOSITION

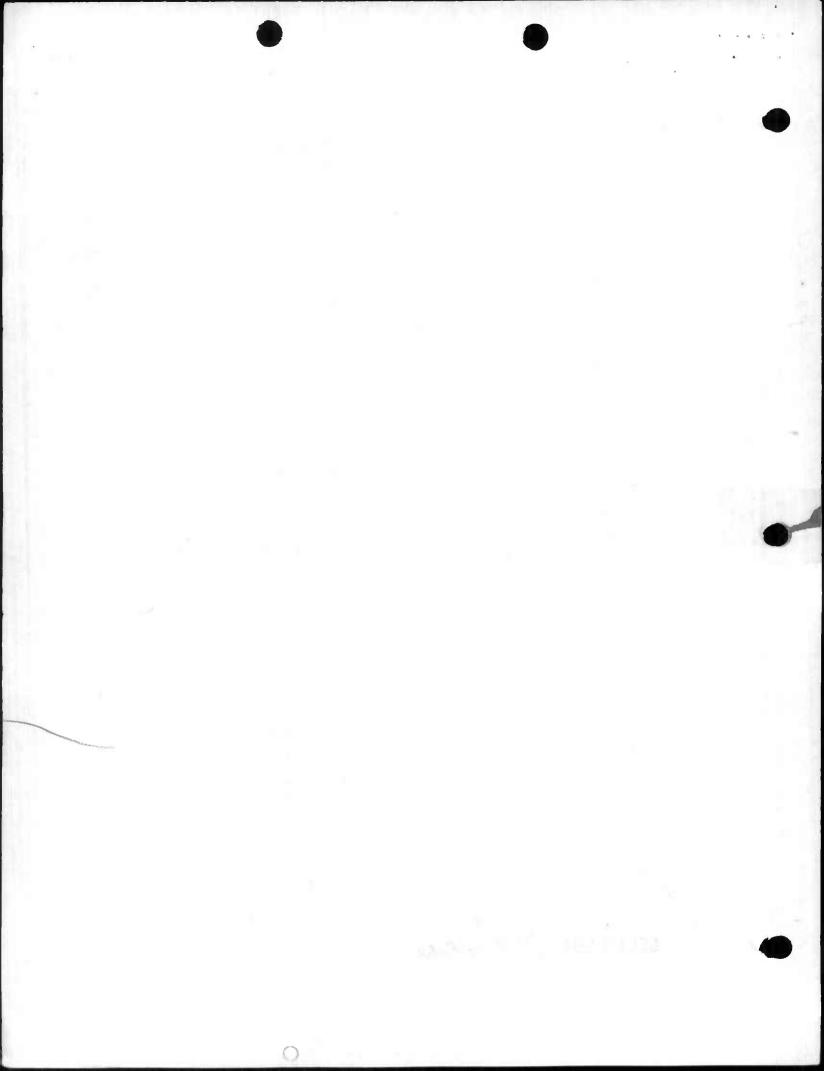
1 Burlel 2 Cremetion 3 Rem
4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION - City or Town, State must cometery, crematory or other place 12-12 Balto. Md. medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Douglass Funeral Service the funeral hours after death. 00/8 an 1701 McCulloh St. la physician and completely filled in by the ne prior to burial, cremation, or removal, 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdisc or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Between **IMMEDIATE CAUSE (Finel Onset and Death** the disease or condition reaulting in death) ACUTE ETHANOL AND NARCOTIC INTOXICATION executed within event. ON OF VITAL RECORDS, P.O. BOX 68760 OUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury other Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events reculting in deeth) LAST 6 signed by the atter Health and Mental I injury, PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO MEDICAL COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 23 shows 1 YES 2 NO has been Dept. of h DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: NDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL Item / 26, PLACE OF OEATH (Check only one) certificate State EXAMINER? HOSPITAL: OTHER: 1 X YES 2 - NO Inpatient 2 - ER/Outpatient 3 - DOA ng Home 5 Residence 6 Other (Specify) the 6 27. MANNER OF DEATH Month, Day, Bed UND this c. TIME OF 28c, INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED is marked, 1 Netural 12-7-94 1 YES 2 NO UNKNOWN BY death After 2 Accident Investigation 28e. PLACE OF INJURY — At home, term, street, factory, office 281. LOCATION 316 N. PACA STREET 3 Sulcide 6 X Could not be COMPLETED 28 4 Homicide FOUND AT HOME BALTIMORÉ, MARYLAND 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(s) and manner ee stated. = TO THE HOWER TO THE FUNERO De filed within 72 IMPORTANT: II MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner ee stated. 29b. SIGNATURE AND TITLESOF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 8 Dennis hute DEC.07,1994 O.C.M.E. 5 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Penn Street, Baltimore, Maryland 21201 31. DATE FILED (MONITY Day, 1887) 32. SEGISTOAS A GHALICE



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within To THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremention, or removal. $\beta \# 3 \% 20$ BALTIMORE, MARYLAND 21215-0020 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	· Add. Inf	o. Fil												
	1 - STATE REGISTRAR		STATE UF I	MARYLAND C	DEPARE	RTMEN ICAT	T OF I	DEA.	AND	MENTAL	HYGIEN REG. NO.			ý.
	1. DECEDENT'S NAME (First			Abena	a As	onad	e Ba	dwah	ene	2. DATE (OF DEATH DA		YEAR 7	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. le	st birthday) YRS.	IF UNDER	DAYS	IF UNDER	MIN.	7. DATE C			a pieri	NPLACE (State or Foreign Maryland
	9a. FACILITY NAME (# not in	nstitution, give s	street and number)			9b. CITY	r, TOWN	OR LOCATI	ON OF D		-1/ /4	9c. COUNTY OF DEATN		DEATN
DIRECTOR	Prince George Hospital Center				er	C	heve	rly				Prince George's		
IREC	10a. STATE	10b. COUNT				Y, TOWN				-				10d. INSIDE CITY LIMITS?
	Md . 10e. STREET AND NUMBER	_	gomery		Ta	akoma		rk	-					1 YES 2 NO
FUNERAL	6731 New H	ampshi	re Avenu	е			1"	2091					A.	WHAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo		12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	YES 2	RMED NO		If yea, sp	CENDENT Coecify Cube	of NISPAN n, Mexica Specify	n, Puerto Ri	(Specify Yes can, stc.)	or No—	Blac	E - American Indian, k, White, stc.
TED	(Specify ant	EDENT'S EDU	CATION completed)	16	ECEDENT'S	work done	during me	ON ost of working	ng	18b.	KIND OF BUS	INESS/INC	DUSTRY	
COMPLET	Elementary/Secondary (0	1-12)	College (1-4 or 5 t	·) ""	Non							3.7		
COM	17. FATNER'S NAME (First, M	iddle, Last)			NOII	е		16. MOTI	HER'S NA	ME (First, Mi	ddle, Maiden		one	
BE	19a. INFORMANT'S NAME (1	ima/Brist)									ahene			
5	Mother	урег-тип)		19							c City or Town			,Md.20912
	20s. METHOD OF DISPOSITI	ION in 3 🗆 Reme	oval_from State	20b. PLACE	ANDDATE	OF DISPOS	SITION (N			OATE		CATION		
	4 Donation 5 Other 21. SIGNATURE OF FUNERA	(Specify) D	y hospita	1	maiory or o			ND ADORES	CO OF FA	OH ITY				
	>					22.	NAME A	ND ADONE:	S OF FA	CILITY				
CERTIFICATION	23. PART I. Enter the di shock, or hi IMMEDIATE CAUSE (Fin disease or condition resulting in death) Sequentially list condition if any, leading to Immediates. Enter UNDERLY! CAUSE (Disease or injuthat Initiated eventa resulting in death) LAS'	ons, diata	a. Proc. DUE TO DUE TO	se on each line	OUENCE OF	mole Fi:								Approximate Intervel Between Onset and Death
PHYSICIAN: MEDICAL C	PART II. Other aignifica	nt condition	s contributing to	death but not r	resulting (in the un	derlying	g cause g	lven in		4a. WAS AN A PERFORI	MED?	245.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIA	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:			OTHER		ACE OF O	EATH (Che	ck only one)				
HYS	1 YES 2 NO		1 Inpatient 2 I		DOA 28b. TIM	4 🗆 Nun	alng Hom		eldence	8 🗆 Other (
ВУ Р		Pending nvestigation	(Month, Da			URY M	28c. INJ WO 1 1 1	RK?	NO	288. DESC	RIBE HOW IN	JURY OCC	CURED	
	3 Suicide 8	Could not be fetermined	26s. PLACE Of building, a	FINJURY — At ho atc. (Specify)	me, term, a	itreet, fact	ory, offic	•			ION (Street ar Town, State)	nd Number	or Aural A	loute Number,
COMPLETED			CIAN: To the best of ax											and manner as stated.
BE (29b. SIGNATURE AND TITLE	OF CERTIFIER	2					29c. LICE	NSE NUM	BER		29d. DATE	SIGNED	(Month, Day, Year)
٩	30. NAME AND ADDRESS OF		1 1	E OF OEATN (ITE	_	-			34:	229			4/2	194
	31. DATE FILED (Month, Day, 1) DEC1 7	G ROV		S SIGNATURE	Cev	rser		>12	(ai	2	Orya	2	Vu	rsers
	DEC1 7	1994	Jalia ather	described	4									*

DHMH-16 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARY		TMENT OF		MENTAL HYGIENI REG. NO.	E	
41645	1. DECEDENT'S NAME (First, Middle, Lest) EVERETT PAUL	BROSE S	SR.			2. DATE OF DEATH DATE DECEMber	13,1994	3. TIME OF DEATH 3;15 P. M
			E (In yrs. lest birthday) 36 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Feb. 9, 1908	8. BIR	THPLACE (State or Foreign
E.	90. FACILITY NAME (If not institution, give street Westminster Nursi				on Location of t		9c. COUNTY OF	
DIRECTOR	RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY	nome		Y, TOWN OR LOC			Ca	rroll
		ltimore	100.01		erstown			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 73 Hanover Road			1	of. ZIP CODE	136		WHAT COUNTRY? USA
B≺	11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced	P. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR	S 2 X NO	If yea, s	CENDENT OF HISPA pecify Cuban, Maxic S 2 NO Spec	NIC ORIGIN? (Specify Yea ean, Puerto Rican, etc.) ify:	Bla Sor	CE — American Indian, ck, White, atc. bully: hite
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12) High School	ON opleted) cotlege (1-4 or 5+)	Ilfe. Do NOT us	vork done during n se retired.)	osl of working oment Ope	16b. KIND OF BUS	Constru	ection
BE CON	17. FATHER'S NAME (First, Middle, Last) William S. I	Brose				MAME (First, Middle, Maiden ama J. Mill		
TO E	Mr. E. Paul Brose	Jr.				Route Number, City or Town Taneytown		1787
	20a. METHOD OF DISPOSITION 1/E] Burial 2		ob. PLACEAND DATE (DATE 20c. LOC 12/16/94	Upperc	Town, State O Balto. Co.
	21. SIGNATURE OF FUNERAL SERVICE LICENS	Elin			ND ADDRESS OF F	Home Reis		erstown Rd.
	23. PAST I. Enter the disesses, or com shock, or heart failure. List	plicationa that caus	ed the death. Do r	not anter tha m	oda of dying, su	ch sa cardiac or respi	ratory arreat,	Approximate interval Between
	iMMEDIATE CAUSE (Final disease or condition resulting in death)				Cora	V.1	L 0.2	Opport and Death
CERTIFICATION	Sequantially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	DUE TO (DR AS	S A CONSEQUENCE DE	¬):				
PHYSICIAN: MEDICAL	PART II. Other significant conditions of Part II. Other Significant Conditions of Part II. Other III. Other III. Other II. Other II. Other II. Other II. Other II. Other II. Other II. Other II. Other II. Other III. Other II. Ot	Prenn	but not reaulting	in the undariying	ng cause given in	Part i. 24a. WAS AN PERFOR	MED?	Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AN: N	DID TOBACCO USE CONTRIB	UTE TO CAUSE				N 🗆		
SICI		OSPITAL:	28. PLACE OF DEAT	OTHER:		6 Other (Specify)		
ву РНУ	27. MANNER OF DEATH 1	28a. DATE OF INJUR (Month, Day, Year		URY	JURY AT ORK? YES 2 NO	28d. DESCRIBE HOW IN	JURY OCCURED	
	3 Suicide 6 Could not be 4 Homicide detarmined	28a. PLACE OF INJU- building, atc. (S)	RY — At homa, farm, (pecify)	street, factory, off	ca	281. LOCATION (Street a City or Town, State)	nd Number or Rura	l Route Number,
COMPLETED	29a. CERTIFIER (Check only one)							
	2 MEDICAL EXAMINER: C	TI THE DESIGN OF EXEMINAT	ion and/or investigatio	n, in my opinion,	29c, LICENSE NU	time, data and placa, and		(a) and manner as stated. (Month, Dev. Year)
TOBE	Pesto 2.1	Monh			1350	2 6	1/2/	14/94
	Robert L. Moss M				Drive	Reistersto	wn, Md.	21136
	DEC16 1994 July	32 REGISTRAR'S P	GNATURE					

prior

Hygiene

the atter

by and

signed I

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has b. Dept.

certificate h

this

the

With

After

DIRECTOR; hours after of

FUNERAL within 72 h

2

31. DATE FILED (Month, Day, Year)

6 1994

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

SAIDI

32. REGISTRAR'S SIGNATURE

Sinden Rendelle

MNIV

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MARYLAND

Pages 1, 2, 3 should

permit.

use as the burial-transit

attending physician.

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(6876	executed with
6	8
0.8	certificate
S, D	death
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O.B.	that
REC	requires
_	NA MA
T A	The
OF VI	PHYSICIAN:
DIVISION OF VITAL RECORDS, P.O. BOX 68760	PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate
	8
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Item# 1.G-film 718 per F.H12/16/94 P.C 1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH Bradlee S. Bradles Breave 250 12 13 94 M 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTN (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign DAYS HOURS 212-64-5736 1- M 2 - F YRS 41 July 31 Germany 9a. FACILITY NAME (If not institution, give street and number) 96 CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR University Hospital Baltimore RESIDENCE OF DECEDENT 100. STATE Florida 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Palm -Md-Beach Boynton Beach Baltimore 1-NAS 2 NO FUNERAL 10a. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 33436 4170 S. Shady Lane 21207 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 TO NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1 Never Married 2 Merried 1 ☐ YES 2 X NO Specify: Specify: BY 3 Widowed 4 Divorced white 18e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Computer Programer Auto 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Andrew C. Brewer Mary A. Smith BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Mary Brewer 8903 Oak Street Boynton Beach, Fla. be 20e. METHOD OF DISPOSITION
1 ☐ Buriel 2 🛣 Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State DATE must Greenmount Crematory 4 Donation 5 Other (Specify) 12/15 Baltimore Maryland examiner 22. NAME AND ADDRESS OF FACILITY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bradley Ashton Funeral Home dees lewn 2134 Willow Spring Road, Balto, Md 21222 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between ahock, or heert failure. List only one cause on each line Onset and Deeth IMMEDIATE CAUSE (Finel the disease or condition DUE TO (OR AS A CONSEQUENCE OF): embolism resulting in death) event, traumatic CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Di abetis 6 Injury, PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AWAILABLE PRIOR TO AND COMPLETION OF CAUSE OF DEATH? 1 TYES 2 T NO Shows 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item OTHER: 1 YES 2 NO 1 Inpetient 2 | FR/Outpetient 3 | DOA ng Home 5 🗆 Reside 6 27. MANNER OF DEATN 28e. DATE OF INJURY 28h TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 40 8 Could not be determined 4 Homicide 28 COMPLE 29e. CERTIFIER
(Chack note)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(e) end menner se attend. -2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner se stated. TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Resident 4 12/13/74

MEDICAL SYSTEM

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		1 - REGISTRAR		CI	ERTIFIC	ATE OF	DEATH		REG. NO.	. 7 .3	0	210
		1. DECEDENT'S NAME (First, Middle, Last)					· · ·	2. DATE OF	DEATH		3.	TIME OF DEATH
		RICHARD	EDWA	RD		BURNS	D D	ECEMBI	ER 6		4	8:30 A
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (in yrs. las		F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, De	BIRTH	8.1	BIRTHPL	ACE (State or Foreign
9		217-76-6785	13€34M 2 □ F	36	YRS.	ONTHS DAYS	HOURS MIN.					vland
pinous	_	9a. FACILITY NAME (If not institution, give s	treet and number)		9	b. CITY, TOWN	OR LOCATION OF D	EATH		9c. COUNTY		
23	СТОВ	#16 CONSTITUTION ROAD PYLESVILLE HARFORD										
les 1,	11.1	10a. STATE 10b. COUNT	Y		10c. CITY,	TOWN OR LOCA	TION				10	d. INSIDE CITY
t. Pages	DIRI	MD	Harfor	a		Dr.100	ville					LIMITS?
permit.		10e. STREET AND NUMBER					. ZIP CODE			10g. CITIZEN	_	T COUNTRY?
ist	FUNERAL	16 Cons	titutio	n Road			21132			U	SA	
020 physician. burial-transit	5	11. MARITAL STATUS	12. WAS DECEDENT FORCES? 1	EVER IN U.S. AF	MED		ENDENT OF HISPA			or No- 14.	RACE -	American Indian, hite, atc.
21215-0020 al or attending physician. for use as the burial-trar	BY	1 Never Merried 2 XX Merried 3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES	X		2 NO Speci		n, arc.)			ite
15- tendir	ED E	15. DECEDENT'S EDU	CATION	18a DE	CEDENT'S US	BUAL OCCUPATION	ON .	I see yo	10. OF BUILD			ice
5 6 2	ETE	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(G		k done during mo		TOD. KIP	NU OF BUSI	NESS/INDUST	нт	
	P	12	College (1-4 of 5 +)		Carpe	enter		Cor	nstr	uctio	n	
AND the hospital detached to once.	COMPLET	17. FATHER'S NAME (First, Middle, Last)					16. MOTHER'S NA					
2 5 5 Z	BE (Richard V	Burns				Iren	e Wai	rner			
MARYLAND retained by the hospit 5 should be detached notified at once.	07	19a. INFORMANT'S NAME (Type/Print)					and Number or Rural					
do as	-	Michelle R. Bu	rns				tion R	d.,Py	_			
ORI 6 may ector, p		20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Rem	oval from State	cemetery, cre	metory or other			DATE		ATION — City		
Page direc		4 Donation 6 Other (Specify)	CENSEE	<u> IBel</u>	Air N	1em.Gd	ns 12	/9/94	Be:	1 Air	, M	D
BALTIMORE, ter death. Page 6 may by the funeral director, page yal.		> (John 18-7)	illett				ins F.		,De	lta,P	Α.,	17314
aft aft		23. PART I. Enter the diseases, preshock, pr heart fallure.	complications that	csused the de	ath. Do not	antar the mo	da of dylng, aud	h as cardiac	or respire	atory srrest,		Approximata
DO P		IMMEDIATE CAUSE (Final	List Drily Dria Caus	se on aach iina	l.							Interval Between Onset and Death
- 3 E -		disease or condition resulting in death)	. CIRRHOSI	S OF THE	LIVER							ļ
N 2 2 - 6				OR AS A CONSE								
atic pur	NO N	Sequentially list conditions,	b	OR AS A CONSE								
BOX ficate be ex physician a ne prior to	Ä	If any, leading to immediata cause. Enter UNDERLYING										į
	Ē	CAUSE (Disesse or Injury that initiated events	DUE TO (OR AS A CONSE	OUENCE OF):							
D. # 8 # 0	CERTIFICATION	resulting in dasth) LAST	d									<u> </u>
Me Me		PART II. Other algolificant condition	is contributing to	death but not r	aaulting in	the underlyin	g cause given in	Part i. 24	n. WAS AN A	UTOPSY	24b. WE	RE AUTOPSY FINDINGS
ORE s that the need by ifth and any in	DICAL								YES 2	NED?	AW	AILABLE PRIOR TO IMPLETION OF CAUSE
REC(requires been signed of Healt	MED							_ "	1152 2	NO		DEATH?
	ä	DID TOBACCO USE CONT	RIBUTE TO CAL	JSE OF DEA	TH YES	□ NO □	UNCERTAI	N \square			• (_ res 2 _ No
	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				(Check only one)						
F VITA SICIAN: The certificate I the State I, or Item) S	TY YES 2 NO	HOSPITAL:	ER/Outpatlant 3		THER: Nursing Hom	a 5 Rasidenca	6 Other (Sp	pecify)			
PHYSICIAN: this certifical with the St inked, or It	표	27. MANNER OF DEATH 1)(X) Natural 5 Pending	28a. DATE OF I (Month, Day		28b. TIME C	OF 28c. INJ	URY AT	28d. DESCRI	BE HOW IN	JURY OCCURE	D	
ON OI DING PHYS After this death with	B	2 Accident Investigation					YES 2 NO					
DIVISION TTENDING A DIRECTOR: After TABLE A TENDING	윤	3 Suicide 8 Could not be detarmined	building, a	INJURY — At ho	me, farm, stre	et, tectory, offic	• 1		N (Street an own, State)	id Number or R	ural Rout	e Number,
		29e. CERTIFIER t CERTIFYING PHYSI	CIAN: To the heat of	- translate de				L				
N S S S	COMPL	(Check only 2 MEDICAL EXAMINE	ICIAN: To the best of n								usa(a) an	d manner on stated
HOSPITAL FUNERA Welthin 78		29b. BANATUHE AND TITLE OF CERTIFIES		1		2000	29c. LICENSE NU					
표 표를 요	B	// dan-	- (1	rke	med)	_					onth, Day, Year)
₽₽% \	5	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	E OF DEATH (ITE	M 27) (Type, Pri	int)	0.C.	м.Е.	DH	CEMBE	R 6	, 1994
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		31. DATE FILED (Month 1200)	- CHELDRICA COM	the conductions	zem	Latte	et. Ba	T L TIIIO	e.	Harvi	allo	Z1ZU1
	1 1	DE01 - 1304 0										

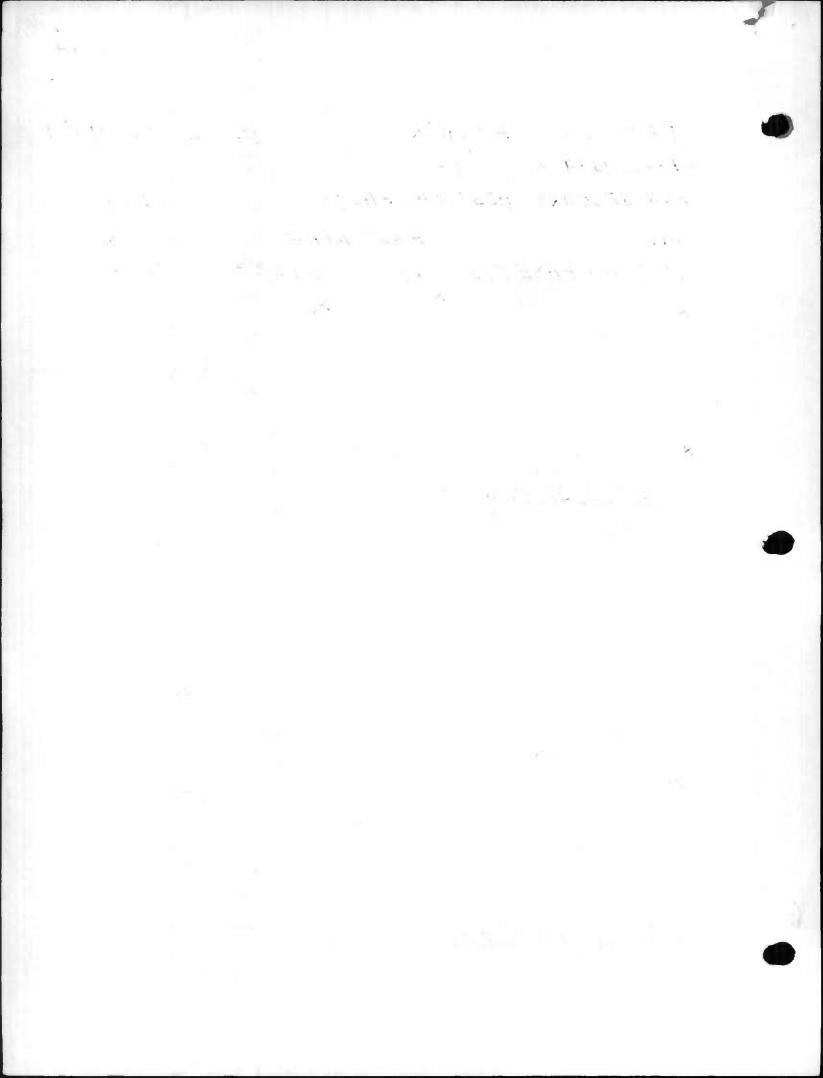
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	FOR 1 - STATE REGISTRAR	STATE OF MARY		IENT OF HEALTH A ATE OF DEATH		HYGIENE REG. NO.		
,	1. DECEDENT'S NAME (First, Middle, La	. Bo	ykin		2. DATE MONTH	OF DEATH DAY	94	3. TIME OF DEATH 9 10 PM
TOR	4. SOCIAL SECURITY NUMBER 244-22-958 9a. FACILITY NAME (If not institution, gi BON SECON RESIDENCE OF DECEDENT	9 1 M 2 F	73 YRS. MO	UNDER 1 YEAR SF UNDER 24 NTHS DAYS HOURS ON CITY, TOWN OR LOCATION	Min. (Month	DF BIRTH (, Day, Year) 4,1921	O. BIRTY COUNTY OF E	TH CAROLIN
DIRECTOR	MD 10b. COU	INTY		OWN OR LOCATION				10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	2020 W-	FAYETTE	57	101. ZIP CODE	223	1,000	US.	WHAT COUNTRY?
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 TYES IF YES, GIVE WAR OR I	2 XNO	13. WAS DECENDENT OF If yes, specify Cuben, 1 YES 2 NO			14. RAC Blac Spec	E — American Indian, ok, White, etc. offy: BLACK
COMPLETED	15. DECEDENT'S E (Specify only highest gr Elementary/Secondary (0-12) N/A		Iffe. Do NOT use n	done during most of worlding	- 1	KIND OF BUSINES		PARROWS P
BE CO	11120011	BOYKIN		M.	ARY SY			
10	TIME THE DOTE D	OYKIN	5504 I	ORESS (Street and Number or LOTHIAN RD	. BALT	IMORE,		1212
	28a, METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 F 4 Donation 8 Other (Specify)	Nemoval from Stata A1	other place)	ON (Name of cometer), created APEL CHURC		4 20c LOCATIO	ON - City or T	
	21. SIGNATURE OF FUNERAL SERVICE	LEWIS I	G. GWYNN		GWYNN	FUNERA		E 21215 TIMORE, MD
	23. PART I. Enter the diseases, shock, or heart fellu IMMEDIATE CAUSE (Finel disease or condition resulting in death)	re. List only one cause on	esch line.	EART FALL		lisc or respirato	ry arrest,	Approximate interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	b. HYPER DUE TO (OR AS	A CONSEQUENCE OF): A CONSEQUENCE OF):					5 years
CERT	resulting in death) LAST	d						_
PHYSICIAN: MEDICAL	PART II. Other significant condi	tions contributing to death	but not resulting in	ina underlying cause giv	ven in Part i.	1 VES 2	77	Is. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
CIAN	25. WAS CASE REFERRED TO MEDICA EXAMINER?	HOSPITAL:	10	26. PLACE OF DEA	ATH (Check only or	10)		
	1 VES 2 NO 27. MANNER OF DEATH 1 Netural 8 Pending Investigati	1 Inpetient 2 ER/Ou 28a. DATE OF INJURY (Month, Day, Year)	7 26b. TIME 0	Property of the second of the	28d. DE	or (Specify) SCRIBE HOW INJUR	RY OCCURED	
TED BY	2 Accident investigate 3 Suicide 8 Could not 4 Homicide detarmine	be 28a. PLACE OF INJUR	RY — At home, farm, stre	et, factory, office	251. LOC City	ATION (Street and h or Yown, State)	Number or Flurei	l Route Number,
COMPLETED	Correct Dray	HYSICIAN: To the best of my kno MINER: On the basis of examinat						(a) and menner as stated.
TO BE CO	296. SIGNATURE AND TITLE OF CERT	IFIER MD			SE NUMBER		d. DATE SIGNE	5 (Ay

PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)

BALTMD 1147 HANOVER 41 21230

Julia of Audion Landy DEC1 6 1994

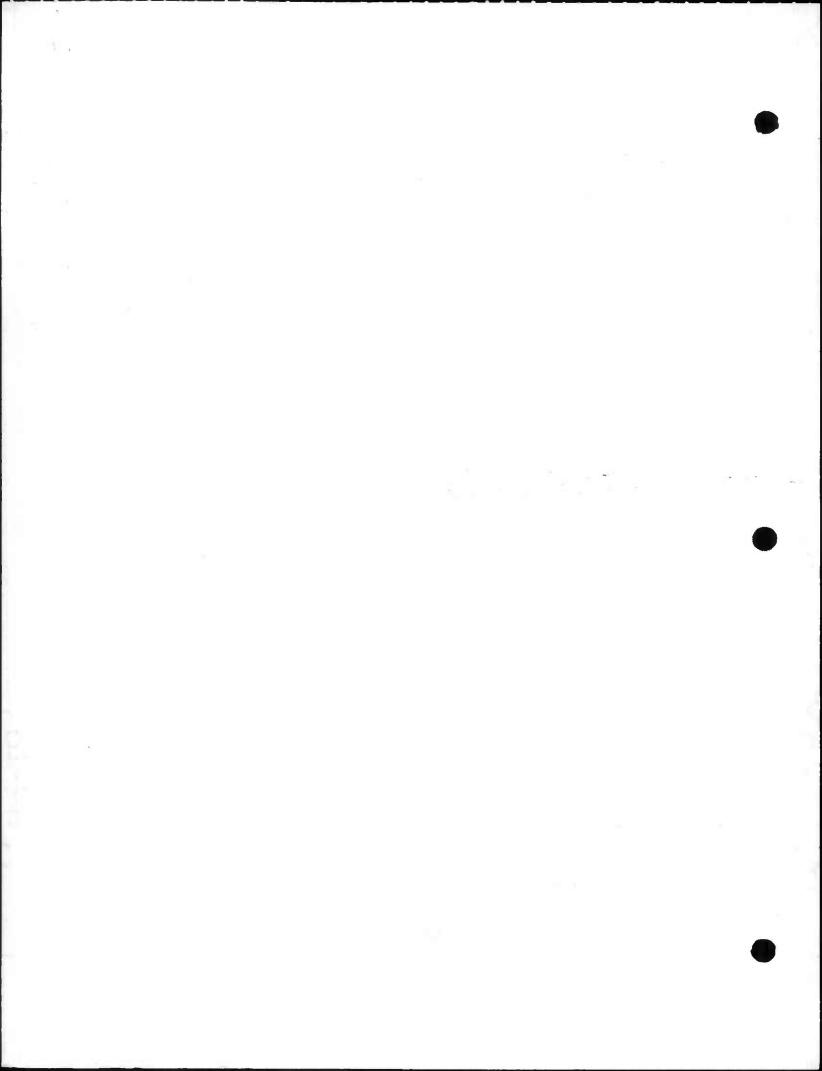


21215-0020	
MARYLAND 3	
BALTIMORE, I	
68760,	

DIVISION OF VITAL RECORDS, P.O. BOX

BALTIMORE, MARYLAND 21215-0020	FINITY The law requires that the death certificate be executed within a nouns after death. Page 6 may be retained by the hospital or attending physician.	neutificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be completely filled in burial transition of completely filled in by the Charles and Many I have burial transit permit.	the medical examiner must be netified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	IP IN OR ATTENDATE PHYSICIAN: The law requires that the death certificate be executed within	ERAL DEFECTOR ATTACKS pertificate has been signed by the attending physician and completely	The man are seen min use state dopt, or regain any wenter proving outsign the medical examiner must be notified at once.	
1	TO CHELLOS	A P	MPOHTAN	1

	1 - FOR STATE REGISTRAR	STATE OF MARYL		MENT OF HEALTH AN	D MENTA	L HYGIEN	E	
	1. DECEDENT'S NAME (First, Middle, Last)					E OF DEATH		3. TIME OF DEATH
3		ALDWIN			DEC		1994 ^{**}	5:30 P. M
	4. SOCIAL SECURITY NUMBER			UNDER 1 YEAR IF UNDER 24 HE	RS. 7. DATE	OF BIRTH	8. 8	BIRTHPLACE (State or Foreign Country)
	220 72 3336	21	O YRS.			Y 19		MARYLAND
æ	98. FACILITY NAME (If not institution, give s GIFT OF HOPE 8			BALTIMORE	F DEATH		9c. COUNTY	OF DEATH
DIRECTOR	RESIDENCE OF DECEDENT		HOTOH	5115411101(5				
IRE	10a. STATE 10b. COUNT	Y		OWN OR LOCATION				10d. INSIDE CITY
	MARYLAND		I	BALTIMORE				1 X YES 2 NO
FUNERAL	10e. STREET AND NUMBER	IOMON ATTONI		10f. ZIP CODE				OF A.
NE	818 N. COLLIN	NGTON AVENU		21205				
	1 Never Married 2 Married	12. WAS DECEDENT EVER II FORCES? 1 YES	2 X NO	13. WAS DECENDENT OF HIS If yes, specify Cuban, Me	exican, Puarto			RACE — American Indian, Black, White, atc.
ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	AIES	1 TES 2 NO S	pecify:			Specify: BLACK
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	18a. DECEDENT'S US	UAL OCCUPATION done during most of working	16	b. KIND OF BUS	INESS/INDUST	
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use n	etired.)				
₹	N/A		UNEMPLO					
	17. FATHER'S NAME (First, Middle, Last)	7.0				Middle, Maiden		
BE	WILLIAM PORTI	SR	Top Mail INC At	DRESS (Street and Number or Ri		ATTHEW		
2	ROSLYN JONES			ASCO PLACE		TO., MI		
	20a METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Rem	201:	PLACE AND DATE OF				CATION — City	
	1 🔀 Burlel 2 🗆 Cremetion 3 🗆 Rem 4 🗆 Donation 6 🗀 Other (Specify)	oval from State cem	netery, cremmory or orgen		/16/9		TIMOR	
	21. SIGNATURE OF SUNTRAL SERVICE LIC	LEWIS T	. GWYNN	22. NAME AND ADDRESS OF				
	Lewis V.	LEWIS T	. OWEIVIN			FUNER		
	23. PART i. Enter the diseases, or o	complications that caused	d the deeth. Do not	enter the mode of dying,	HELGE such as car	diec or reapi	E. BA	LTIMORE, MD.
	ehock, or heart fellure.	Liet only one ceuse on e	ech ilne.					interval Batween Onset and Death
	diseese or condition resulting in death)	· acaure	d loum	unodeficie	well	Sima	con	0
		DUE TO (OR AS A	CONSEQUENCE OF):		/-	9		
NO	Sequentially ilet conditions,	b						
AT	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (UH AS A	CONSEQUENCE DF):					
임	CAUSE (Diseese or injury 5 c.							
	that initiated eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST							
E		DUE TO (OR AS A	CONSEQUENCE OF):					
CERTIFICATION	resulting in death) LAST	d						
AL.		d		he underlying ceuee given	in Part i.	24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMMUNICATION OF CAUSE
AL.	resulting in death) LAST	d		he underlying ceuee given	n in Part i.		MED?	
AL.	PART II. Other eignificant condition	d. la contributing to death b	out not resulting in t			PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
AL.	resulting in death) LAST	d. a contributing to death b	out not resulting in t	□ NO □ UNCERT		PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
AL.	PART II. Other eignificant condition DID TOBACCO USE CONTI	a contributing to death b	OF DEATH YES 26. PLACE OF DEATH	□ NO □ UNCERT	AIN 🗆	PERFOR	MED? M҈NO	AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
AL.	PART II. Other eignificant condition DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	DF DEATH YES 26. PLACE OF DEATH (Detient 3 □ DOA 4 28b. TIME 0	NO UNCERT	AIN D	PERFOR	MED? M NO OSPIC	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO HOME
PHYSICIAN: MEDICAL	PART II. Other eignificant condition DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	RIBUTE TO CAUSE O	DEPTH YES 26. PLACE OF DEATH / Operation 1 3 D DOA 4	NO UNCERT	AIN Dance 6 Oth	PERFOR	MED? M NO OSPIC	AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO HOME
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BY PHYSICIAN: MEDICAL	PART II. Other eignificant condition DID TOBACCO USE CONTI 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be detarmined 29a. CERTIFIER (Check only	RIBUTE TO CAUSE O HOSPITAL: 1 Inpetient 2 ER/Outp 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, atc. (Spec	DEATH YES 26. PLACE OF DEATH (Destinat 3 DOA 4 26b. TIME 0 INJURY 7 — At home, farm, streethy)	NO UNCERT	AIN Date 6 Other 26d, DE 28f. LOX City	PERFOR t YES 2 Fr (Specify) H SCRIBE HOW IF CATION (Street a or Town, State)	MED? M NO OSPIC JURY OCCURE and Number or R	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO E HOME
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retained by the hospital or Pe death. Page 6 may the death certificate be executed

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760 OR ATTENDING PHYSICIAN:

Pages 1, 2, 3 should permit. use as the burial-transit attending physician. be detached for funeral director, page 5 should notified pe must examiner hours after d ed in by the 1 medical in and completely filled in by it to burial, cremation, or remothe event, traumatic signed by the attending physician Health and Mental Hygiene prior to other 6 any Shows been rt. of h certificate has be th the State Dept. 23 this c marked, After DIRECTOR: Aft hours after de-item 28 is r

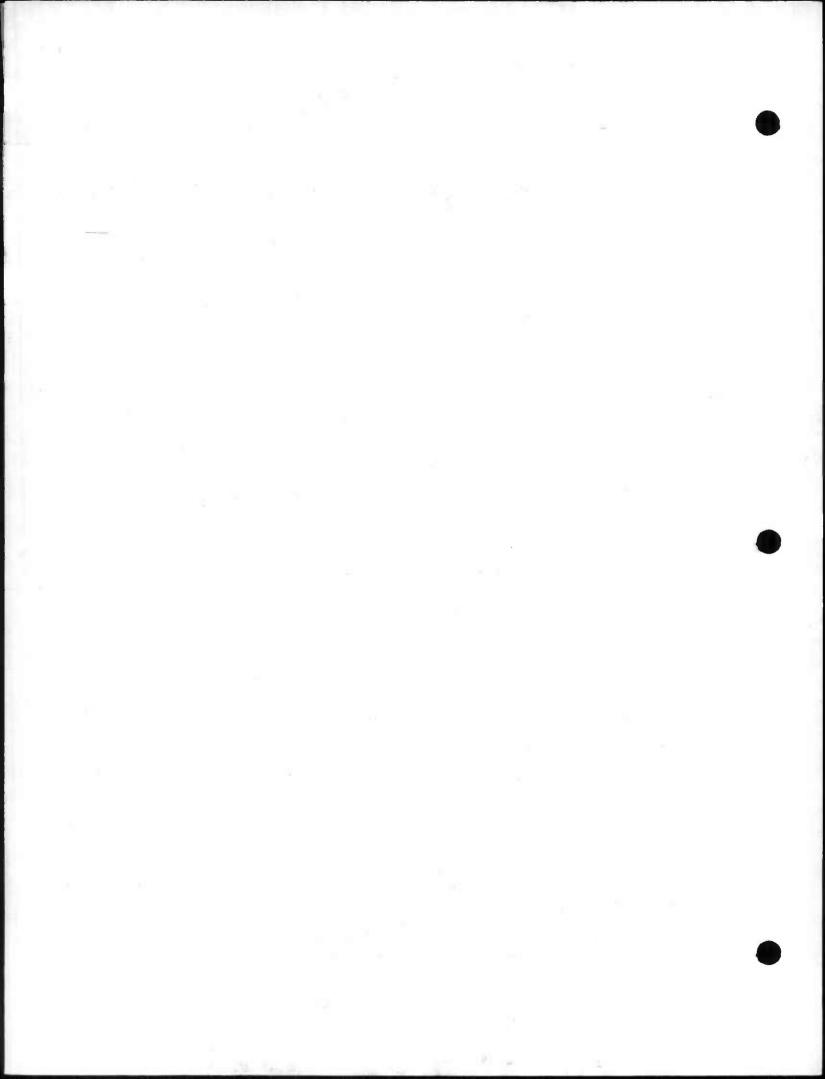
ITEMS: 1. & 10d, PER F.H. FILM G-718 12/16/94 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF GEATH YEAR ROBERT JOHN COOK DECEMBER 1994 0230 10 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign May 29 1915 387-12-4962 1 M 2 F 79 YRS Wisconsin 9e. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH DIRECTOR GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE RESIDENCE OF DECEDENT 10a, STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore Towson VES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8227 Burnley Rd. 21204 USA 12. WAS OECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indien, Block, White, etc. FORCES? 1 XYES 2 NO 1 Never Married 2 Merried 1 TYES 2 NO Specify: Specify: White В 3 Wildowed 4 Divorced COMPLETED 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. OECEDENT'S EDUCATION 16b. KINO OF BUSINESS/INDUSTRY (Specify Elementary/Secondary (0-12) College (1-4 or 5+) 12 Proprietor Hearing Aids 17, FATNER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Meiden Sumeme) Ernie H. Cook Mamie Hochquertel BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Mrs. Neva L. Cook 8227 Burnley Rd., Towson, MD 21204 20a METHOD OF DISPOSITION
1) Burlel 2 Cremetion 3 Ra 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE Moreland Memorial Park 4 Donation 5 Other (Specify) 12/13 Hillendale, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Bryan W. Lemmon Funeral Home Clary 10 W. Padonia Rd., Timonium, MD 21093 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock or Beart failure. List only one cause der Intervel Between IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) AND Ris De Ayloxia ENCEPHOLOGOTUM 10 Piusou CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING alus X CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events or the MS, SE can to Fall resulting in death) LAST HOLNOURI HANDENT PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL Alzhano 1 yes 2 no MAILABLE PRIOR TO COMPLETION OF CAUSE Mr Hirle No cout OF DEATH? 1/ATOUBL 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES PHYSICIAN: NO I 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) **EXAMINER?** OTHER: 1 YES 2 NO Inpatient 2 | ER/Outpatient 3 | DOA 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED 1 Natural 5 Pending BA-1ENT FEN 11/22/94 AM OR FUM 1 YES BY Investigation 281. LOCATION (Street and Number or Rural Route Number City or Town, State) 5 15 8 mg F Frey 1000 28e. PLACE OF INJURY — At home, ferm, street, factory, office 3 Suicide 6 Could not be COMPLETED 4 Homicide Wirning Herte Brightund) MELLICAN 64001118 If Item 2 (Check only one) 29e. CERTIFIER 721055 TO THE HOSPITA
TO THE FUNERAL
DE filed within 72
IMPORTANT: II 2 MEDICAL EXAMINER: On 29b. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) BE previto Viero M 12110194

B'OF PERSON WNO COMPLETEO CAUSE OF DEATH (ITEM 27) (Bypo, Print)

32. REGISTRAR'S EIGHT THE

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BALTIMORE, MARYLAND 21215-0020	cuted within a nours after death. Page 6 may be retained by the hospital or attending physician.	e burial-tran
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DIVISION OF VITAL RECORDS, P.O. BOX 68

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hin nours after death. Page 6 r	tely filled in by the funeral director mation, or removal.	traumatic event, the medical examiner mu-
L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within	he attending physician and complete Mental Hygiene prior to burial, cren	ury, or other traumatic event
YSICIAN: The law requires that the	s certificate has been signed by the the State Dept. of Health and N	d, or Item 23 shows any in
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within whom's after death. Page 6 may be retained by the hospi	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MA		ENT OF HEALTH AND NATE OF DEATH	NENTAL HYGIENE REG. NO.	
		STER		2. DATE OF DEATH	S. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 214-22-7101 1 M 2 N 9a. FACILITY NAME (if not inatifution, give street and number)	81 YRS. MOHT	NDER 1 YEAR IF UNDER 24 HRS. HB DAYS HOURS MIN. CITY, TOWN OR LOCATION OF DE	05 -29-1913	BIRTHPLACE (State or Foreign Country)
CTOR	NORTH WEST HOSPI-	TAL F	RANDALLS		LTIMORE
FUNERAL DIRECTOR	10a. STASE WARULAND 10b. COUNTY BALTING 10a. STREETAND NUMBER	OCE 10c. CITY, TO	WN OR LOCATION 101, ZIP CODE		10d. INSIDE CITY LIMITS? 1 YES 2
UNERA	5412 OLS COURT A	VER IN U.S. ARMED	2/2 C	07 4	N OF WHAT COUNTRY?
ВУ	1 Never Married 2 Married 3 Wildowed 4 Divorced FORCES? 1 FYES, GIVE WAR	YES 2 NO OR DATES	If yes, specify Cuban, Maxican 1 YES 2 NO Specify:	, Puerto Rican, atc.)	Black, Write, atc. Specify: BLACK
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	18e. DECEDENT'S USUA (Give kind of work of life. Do NOT use retir	one during most of working	FOOD SEL	
BE COM	17. FATHER'S NAME (First, Middle, Leat)	2077	18. MOTHER'S NAM	IE (First, Middle, Maiden Surname)	SMITH
TO B	TOYCE BOWYER	20 09	RESS (Street and Number or Rural RidEN) HILL C	oute Number, City or Town, State, Zip Co. T BALTO, Md.	2/207
	20s. METHOD OF DISPOSITION 1 Suriel 2 Cremetton 3 Removal from State 4 Donatton 8 Other (Specify) 21. SIGNATURE OF FUNDRAL SERVICE LIBERTY	20b. PLACE AND DATE OF DIS cemelery repetion or other pi	15 NEN. PARK	12/15 BALTIN	WORE, Wd.
	23. PARTY Enter the diseases, or complications that co	award the death. Do not a	22. NAME AND ADDRESS OF EACH WITH AND CO. N. N.	OPTH ANE	AUNITY FIA
	ahock, or heart failure. List only one ceuse IMMEDIATE CAUSE (Final disease or condition resulting in death) a. PNEW	on each lina. MONA AS A CONSEQUENCE OF:	mer the mode of dying, soch	as cardiac or respiratory arres	Approximata interval Between Onset and Daath
CERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury	CARCINC R AS A CONSEQUENCE OF):) M A		12 MON7H
PHYSICIAN: MEDICAL CE	PART II. Other algnificent conditions contributing to de	ath but not resulting in th	e underlying cause given in f	Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 //npetion: 2 El		26. PLACE OF DEATH (Che HER: Nursing Home 5 Residence 4		
ву рну	27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day. 2 Accident Investigation	JURY 28b. TIME OF	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCU	REO
		NJURY — At home, farm, street, . (Specify)	factory, office	281. LOCATION (Street and Number or City or Town, State)	Rural Route Number,
COMPLETED	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my one) 2 MEDICAL EXAMINER: On the basis of axem				
TO BE	29b. SIGNATURE AND TITLE OF CERTIFIER 30. HAME AD ADDRESS OF PERSON WHO COMPLETED CAUSE I	MD	D45		2 12 9 4
	1504 OID COURT ROAD	RANDAU		ND 21133	
	DEC1 6 1994 July	DRUGGE Randolly			



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within mours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permi	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	(MONDTANT Is form to be been described as the second second as the second secon
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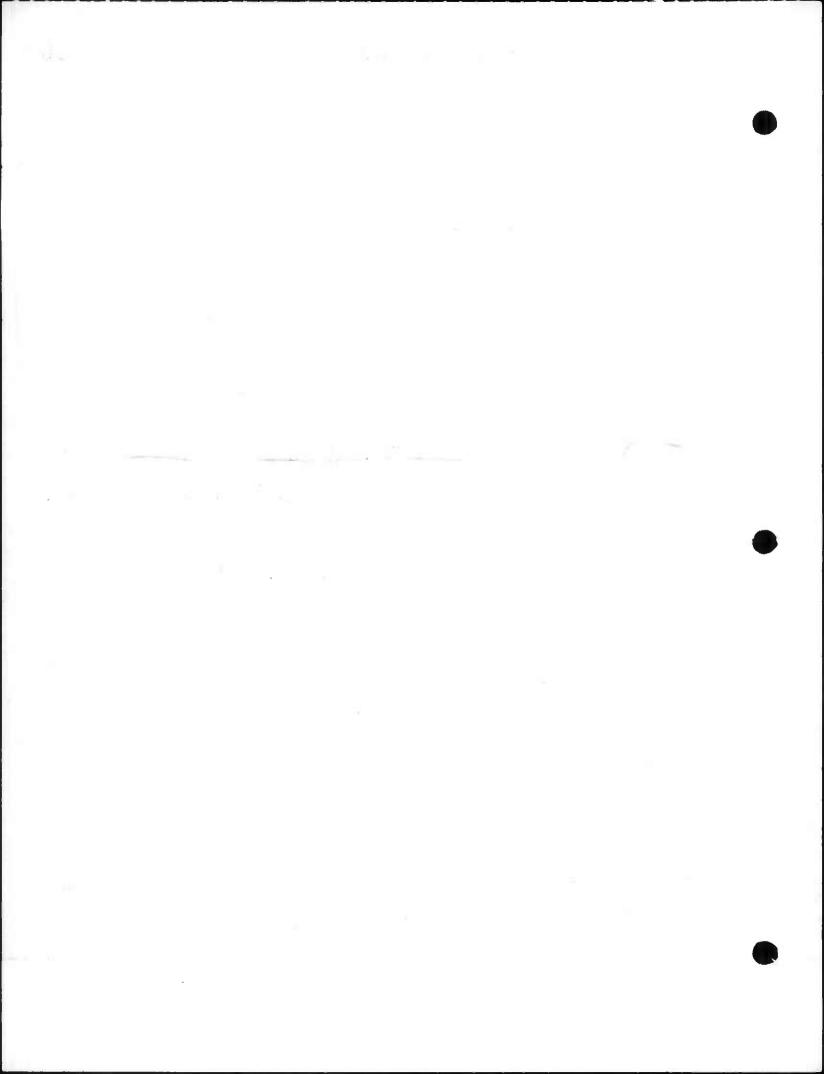
DEC

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH CLINE Bascum RNEST 730 12 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS HOURS 240-05-3369 1 M 2 F VDC SEPT.3,1908 86 NORTH CAROLINA 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH eaton Deaton Medical Center BALTIMORE DIRECTO 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND BALTIMORE BALTIMORE 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 30 N. PROSPECT AVENUE 21228 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3

M Widowed 4 □ Divorced Specify: WHITE COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY nentary/Secondary (0-12) College (1-4 or 5+) H/S GRAD MECHANIC SOLO CUP CO. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET (UNKNOWN) BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 mrs. anna kay romeo 4502 LINDEN AVENUE - HALETHORPE, MD. 21227 20s. METHOD OF DISPOSITION

The Burial 2 Cremation 3 Ramoval from Stata
4 Donalion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION 20c. LOCATION -ELKRIDGE Balto, MD. Greenmount Crematory MEATHERTHE 21. SIGNATURE OF PUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. Tours 4107 WILKENS AVENUE-BALTIMORE, MD 21229 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or reepiratory errest, shock, or heart feilure. List only one ceuse on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Fine) disease or condition NUMONIA 2 weeks resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Obstructor Disease Years CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEQUENCE OF) that initieted evente resulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 THO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES MY NO WILL UNCERTAIN WILL NO WILL UNCERTAIN WILL NO W 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO Inpatiant 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Realdence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO В Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicida 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be detarmined COMPLETED 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND JITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE, MD 038675 12/13 au NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MESHULAM 1147 HANOVER ST BALTIMORE 21230 31. DATE FILED (Month, Day, Year) 32. PEGIŞTRAR'S SIGNATURE JULIA O'BUNGLIAN KONSOLL 16 1994



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31. DATE FILED (MONTE DE 1994

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH Eva Margaret Callender December 13,1994 10:41 AM M 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 09/04/1928 6. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS MIN. Maryland 1 M 2 F 215-22-4275 YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH John Hopkins Bayview Medical Ctr. DIRECTOR Baltimore City RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Maryland Dundalk 1 TYES 2 X NO FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 7476 Rabon Avenue 21222 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 XNO Specify: 2 NO 1 Never Married 2 X Married IF YES, GIVE WAR OR DATES В¥ Specify. White 3 Widowed 4 Divorced 0 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY during most of working (Give kind of work done life. Do NOT use retired.) COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) 10 Years Homemaker Own Hame 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Frederick J. Hunger</u> Margaret Hobbs BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. George J. Callender 7476 Rabon Avenue Dundalk, Maryland 21222 20a, METHOD OF DISPOSITION

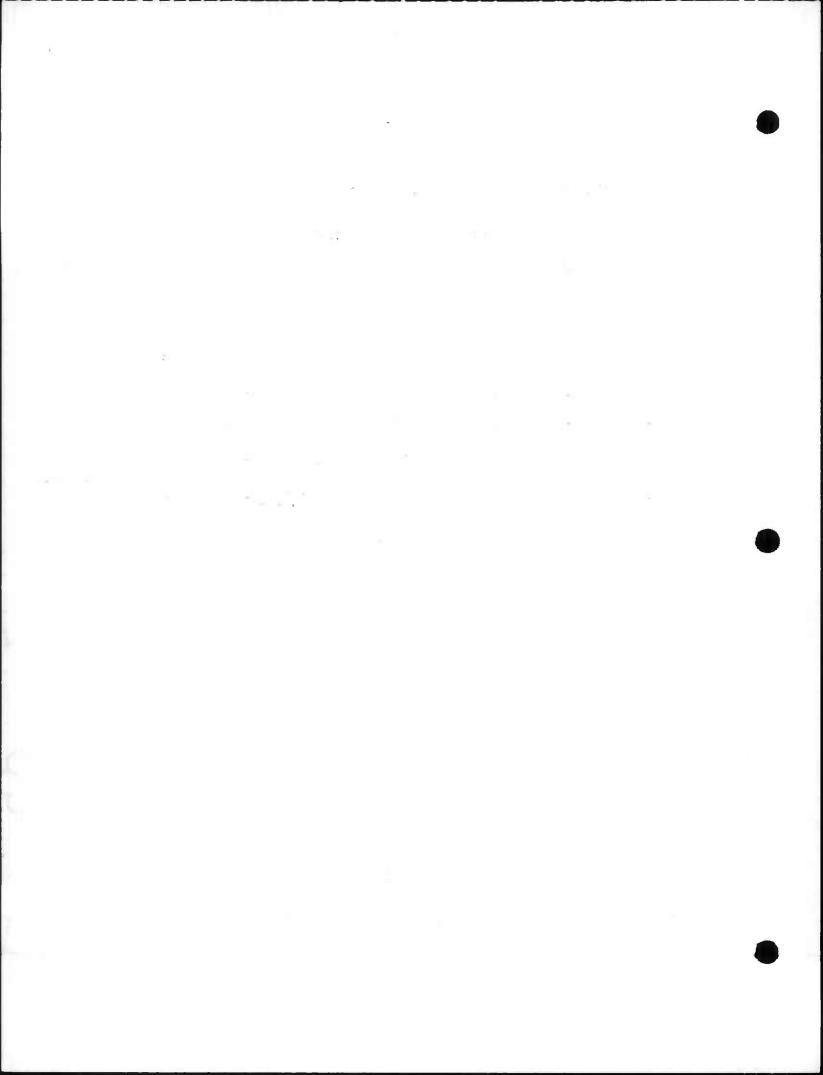
LXX Burlel 2 Cremetton 3 Removal from State

Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Sacred Heart of Jesus Cem. 12/17/94 Dundalk, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Duda-Ruck Funeral Home of Dundalk, Inc. 4 7922 Wise Ave. Dundalk, Maryland 23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or haart failure. List only one cause on each line. interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition DRONARY reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF). if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24s. WAS AN AUTOPSY Hypertension 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL 1 TES 2 NO Inpetient 2 ER/Outpetient 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural N 5 Pending 1 YES 2 NO BY 2 Accident 26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) PLETED 6 Could not be 4 Homicide determined CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. E CO 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) D35411

6918 Ridge

md. 2/23

12-13-94

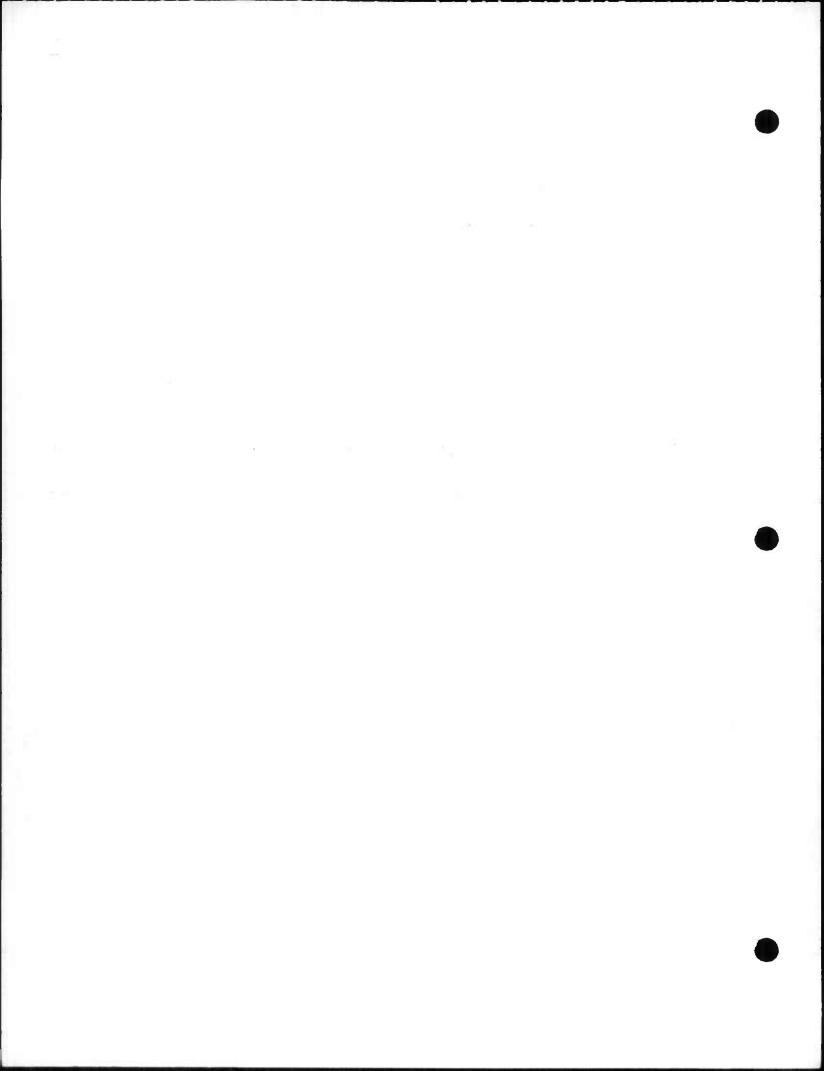


OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

	1. DECEDENT'S NAME (First, Middle, Last) Clara	Clark				2. DATE OF DEATH DEC. 13, I	994 YEA	3. TIME OF DEATH
		SEX 6. AGE (1	In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IE UMDED 24 MDS	7. DATE OF BIRTH (Month, Day, Year) May 28,1	I a nu	RTHPLACE (State or Foreign unity) Lifornia
TOR	99. FACILITY NAME (If not institution, give street Chesapeake Nurs		r	96. CITY, TOWN O	OR LOCATION OF DE	ATH	9c. COUNTY O	Arundel
DIRECTOR	10e STATE 10h COUNTY	Arundel	10c. CITY An	napoli	TION S			10d. INSIDE CITY LIMITS? 1 📉 YES 2 🗌 NO
FUNERAL	1238 Mt. Pleasa	nt Drive		10	21401		10g. CITIZEN O	E WHAT COUNTRY? USA
B	11. MARITAL STATUS 12 1	. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 XNO	If yee, sp	ENDENT OF HISPANI ecity Cuban, Mexicen 2 NO Specity.		В	ACE — American Indian, leck, White, etc.
COMPLETED	15. DECEDENT'S EOUCATI (Specify only highest grade con Elementary/Secondery (0-12) 9	ON ipleted) ollege (1-4 or 5+)		JSUAL OCCUPATION ork done during more retired.) IEMaker	st of working	16b. KIND OF BUS	Own H	
TO BE COM	17. FATHER'S NAME (First, Middle, Last) Frank Fielder					AE (First, Middle, Maiden a St. Ra		
10	190. INFORMANT'S NAME (Type/Print) Frances Locklai:	r	196. MAILING 1238	Mt. Pl	easant	oute Number, City or Yow Drive, A	n, State, Zip Code; nnapol	is,MD 2140
	20e. METHOD OF DISPOSITION 1X Burlal 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	Trom State	PLACE AND DATE O	nººNati	onal Ce		Arlin	gton, VA
	Datel J ar	41				eral Hom ve. Anna		MD 21401
CERTIFICATION	23. PART i. Enter the diseases, or com ahock, or heart failure. List immediate cause or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF); (Sm	de of dying, such	as cerdiec or respi	fratory arrest,	Approximate Interval Between Onset and Death P S
MEDICAL	PART II. Other significent conditions of					PERFOR	RMED?	24b. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
PHYSICIAN:			26. PLACE OF DEATI	(Check only one)	UNCEKIAIN			
à	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 26c. INJ	URY AT PRK? YES 2 NO	26d. DESCRIBE HOW I	NJURY OCCURED	
ETED	3 Suicide a Could not be determined	28e, PLACE OF INJURY building, etc. (Speci	— At home, ferm, at	reet, fectory, offic		28t. LOCATION (Street e City or Town, State)		al Route Number,
O BE COMPLE	CERTIFIER (Check only 2 MEDICAL EXAMINER: C							ie(e) end menner existated.
O BE	866. SIGNATURE AND TITLE OF CENTIFIER M	n			29c. LICENSE NUM	757		ED (Month, Day, Year)
0	30, NAME AND ADDRESS OF PERSON WHO CO	DMPLETED CAUSE OF OEA	77 PG	Print) VINSUL	A GANI	mnomo /	_	
	31. DATE ELE 106 1994 Juli	38 REGISTRAR'S GON	ALL					

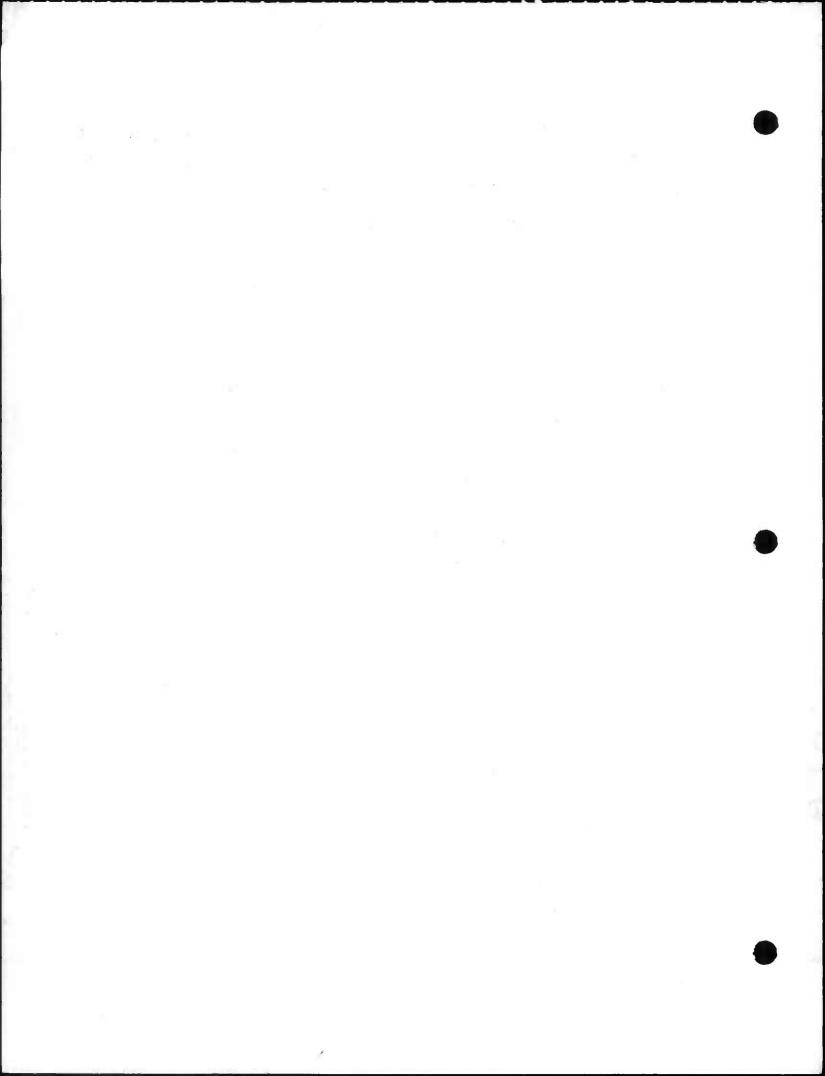
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



DIVISION OF VITAL RECORDS, P.O. BOX 68760.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	HEGISTHAH				CERTIF	CALE	UF	UEAI	<u> </u>	REG. N	O		
	1. DECEDENT'S NAME (First	, Middle, Last)								2. DATE OF DEATH MONTH	DAY	YEAR	3. TIME OF DEATH
	James Th	amas C	OX TU							December		1991	9:30P M
	4. SOCIAL SECURITY NUME	BER			s. last birthday)	IF UNDER 1		IF UNDER		7. DATE OF BIRTH	,	A BIRTH	IPLACE (State or Foreign
	220-74-98	19	1 🔀 M 2 🗆 F	36	YRS.	MONTHS	DAYS	HOURS	MIN.	sept. 4,	1958	Was	hington,DC
	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY,	TOWN C	R LOCATIO	ON OF DE	ATH	9c. COU	NTY OF D	EATH
18	Doctors Con	munity	y Hospita	1		Lar	ihai	m			Pri	nce	George
СТОВ	RESIDENCE OF DEC										1		ccorge
DIRE	10a. STATE MD	Anne	Arunde	1	E.G.	y, town of gewa	LOCAT	ION					10d. INSIDE CITY LIMITS?
ā						, oa							1 X YES 2 NO
I ₹	10e. STREET AND NUMBER		D I					ZIP CODE				_	VHAT COUNTRY?
빌	3912 Germ	antow	n Road					103	/		U	SA	
FU	tt. MARITAL STATUS		12. WAS DECEDENT FORCES? 1			13. W	AS DEC	ENDENT O	F HISPAN	IIC ORIGIN? (Specify)	es or No—	14. RACI	E — American Indian, k, White, atc.
ВУ	1 Never Married 2 3 Widowed 4 Divo		IF YES, GIVE WA					2 XNO					"Y White
													WILLEE
		EDENT'S EDU y highest grade		16a	(Give kind of a life. Do NOT us	vork done di	CUPATIO uring mo:	ON SI of workin	g	16b. KIND OF B	USINESS/INI	DUSTRY	•
1 -1	Elementary/Secondary (0	l-t2)	College (t-4 or 5+)		Instri					Co	smot	0100	
COMP				-	LIISCI	10.00.	_					0100	3 Y
8	17. FATHER'S NAME (First, M James Tho		OV TIT							ME (First, Middle, Maide		L	
띪		_	.OX 111							Marie			
p	19a. INFORMANT'S NAME (1									loute Number, City or To			0.27
	Wendy Spo				102 1	welci	n s	Dr.	. EC	lgewater	, MD	2	037
	20s. METHOD OF DISPOSIT 1 □ Burlel 2 □XCremetic	n 3 🗆 Ram	oval from State		CE AND DATE					1	OCATION —		
	4 ☐ Donation 5 ☐ Other 21. SIGNATURE OF FUNE HA			Meti	ro Cre						Balt.	imor	e, MD
		-/	1/1/1	//		22. N	ame an	esty	SS OF FAC	ıneral H	ome.	P.A	١.
	Dan	0	t ceru	1						Ave. An			
	23. PART i. Entar tha d	seasea, or o	complications that	caused the	daath. Do r	ot antar t	ha mo	da of dyl	ng, sucl	aa cardiac or rea	piratory an	reat,	Approximate
	ahock, or h	aart fallura.	Liat only one caus	e on aach	lina.								Interval Between Onset and Death
	disease or condition	- L	& cur	B	right	ator	M	3	For	ALD O			onest and bagin
	reaulting in death)		а.		NSEQUENCE C		7						2 WKS
-		_	topto			Ine	11	new	vi-				
Ö	Sequentially list conditi if any, leading to imme		U		NSEQUENCE OF	D:							_
CAT	cause. Enter UNDERLY	NG	Ina	mo	3487	1	F	~	ga	U Ba	Ten	. 0)	
CERTIFICATION	CAUSE (Disease or inju that initiated events	ry	W		NSEQUENCE OF				-V		, ,		
F	reaulting in death) LAS	τ	N8	15									10 yrs
- 1													-
EDICAL	PART II. Other algnifica	nt condition	a contributing to d	leath but n	ot resulting	n the und	lerlylng	causa g	givan in		N AUTOPSY	24b	WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
ä										1 YES			COMPLETION OF CAUSE OF DEATH?
ME													1 YES 2 NO
	DID TOBACCO U	SE CONTI	RIBUTE TO CAL	JSE OF D	EATH YE	S 🗆 N	0 🗆	UNC	ERTAIN	1 🗆			
S	25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSEMAL:	28. P	LACE OF DEAT								
PHYSICIAN:	1 TES 2 NO		impetient) 2 🗆	ER/Outpatien	t 3 🗆 DOA	OTHER:		5 🗆 Ra	sidenca	6 Other (Specify)			
E	27. MANNER OF DEATH		(Mogh, Day		26b. TIM	E OF 2	6c. INJU			28d. DESCRIBE HOW	INJURY OC	CURED	
ВУ		Pending investigation				M		ES 2 [NO				- 1
	2 Suitable	Could not be	26a. PLACE OF	INJURY — A	t home, farm, a	treet, factor	ry, office	,		28f. LOCATION (Stree	and Number	or Rural F	Route Number,
田		determined	bonding, a	te. (Opecity)						City or Town, Stat	9)		
WPLETE	29a. CERTIFIER	IFYING PHYSI	CIAN: To the best of m	w knowledge	death occurre	d at the tim	o dete	and alone	and due	to the source(s) and			
A) and manner as stated.
0	386. SIGNATURE AND TITLE												
W	SIGNATURE AND TITLE	OF CERTIFIER			0 .		- 1	29c. LICE			29d, DAT	~	(Month, Day, Year)
2	The same area.	100) Pr	KIEH	MADO	5		VV	619	. 1		12-1	494
	30. NAME AND ADDRESS OF	PERSON WH	COMPLETEO CAUSE	OF OEATH (6		. A	
		<u> </u>	MILA,	m		1376	>	YM	AB	V- SAIBLE	W	YLY) FOR ROW
	DECT 6 19	94 4	32 REGISTRAR	Tara	ŧ								
		- 0											



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

1 . STATE

RE	EGISTRAR		CER	TIFIC	ATE OF	DEATH	REG. NO		
	DOROTHY	Α	(CALLE	ELA		2. DATE OF DEATH MONTH Dec 10	4 1994 YEAR	5:03 pm
219	9-10-0671	1 □ M 2 🛣 F	AGE (In yrs. last birt		UNDER 1 YEAR NTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	Cot	THPLACE (State or Foreign Intry) anuland
- 10	Saint Joseph Medi			9b		son, Mar	EATH	9c. COUNTY OF	DEATH TIMORE
RESID	ATE 10b, COUNTY		10	o CITY TO	OWN OR LOCAT	TON			
E /	Nd. Bal	timone			timon	e			10d. INSIDE CITY LIMITS? 1 YES XX NO
S	REET AND NUMBER 421 Philadel	phia Rd.			101	2/237		10g. CITIZEN O	· A .
3 🗆 W	RITAL STATUS ever Married 2 Married //dowed 4 XDivorced	12. WAS DECEDENT E FORCES? 1 _ IF YES, GIVE WAR	YES 2 XNO		If yes, sp	ENDENT OF HISPAI ecity Cuban, Maxica 2 X NO Specif	NC ORIGIN? (Specify Yearn, Puerto Rican, etc.)	Bi	CE — American Indian, ack, Whita, atc. ecity: White
Elen	15. DECEDENT'S EDUC (Specify only highest grade mentary/Secondary (0-12)	completed)	16a. DECEDI (Give ki life. Do i	ENT'S USU ind of work NOT use re	JAL OCCUPATIO done during mo tired.)	ON st of working	16b. KIND OF BU	SINESS/INDUSTRY	
		College (1-4 or 5+)			Aide				Schools
Ihe	omas C. Wood	en					me (First, Middle, Meiden Inna Linh		
19a, INF	FORMANT'S NAME (Type/Print)					nd Number or Rural	Route Number, City or Tow	n, State, Zip Code)	
I'I R. J.	1. Many M. B	ailey					Rd. Balt		
N XBu	ETHOD OF DISPOSITION urial 2 Cremation 3 Remo	oval from State	20b. PLACE AND I cemetery, cremeto Parkwa	ry or other p	(em.		DATE 200. LO	Lto. M	d.
21. SIGN	NATURE OF FUNERAL SERVICE LIC	Smit	2		22, NAME AN Hart 7527	ley Mil Harlon	Ler Fune	nal Ho	me d. 21234
23. PA	ARTA. Enter the diseases, or cahock, or heart fellure. I	omplications that c	eused the death.	Do not	enter the mo	de of dying, suc	h aa cardiac or reap	Iratory srrest,	Approximata
	DIATE CAUSE (Finel	List only one ceuse	on each line.						Onast and Deati
	ing in deeth)	PNEUMO		105.05					1WEEK
		METASTA	TIC BREA		ARCINO	MA			2 YEAR
If any, cause.	entially liet conditions, , laeding to immediate . Enter UNDERLYING		R AS A CONSEQUEN				W. 5		
thet In	E (Diseese or Injury intleted eventa ing in deeth) LAST	DUE TO (OF	R AS A CONSEQUEN	ICE OF):					
	II. Other elgolffeest condition		-45.1						
PART	II. Other significent conditions	s contributing to de	ath but not reeul	iting in ti	he underlying	ceuse given in	Part I. 24a. WAS AN PERFOR	RMED?	4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
							_		1 - YES 2 NO
	CASE REFERRED TO MEDICAL				2ê. PL	ACE OF DEATH (Ch	eck only one)		
1 🗆	YES 2 NO	HOSPITAL:	R/Outpetient 3 🗆 D		THER: Nursing Hom	e 5 🗌 Rasidenca	6 Other (Specify)		
	NER OF DEATH	28a. DATE OF IN. (Month, Day,		b. TIME OF		URY AT RK?	26d. DESCRIBE HOW	NJURY OCCURED	
2 🖺	Accident Investigation					ES 2 ND			
40	Suicide 6 Could not be determined	28e, PLACE OF II building, atc	NJURY — At home, 1 . (Specify)	lerm, stree	it, factory, offici	•	281. LOCATION (Street and City or Town, State)	and Number or Run	al Route Number,
29a. CEF (Che one)	ock only						to the cause(a) and mai		e(s) and manner as stated.
201- 210	NATURE AND TITLE OF CERTIFIER	- 0				29c. LICENSE NUI			ED (Month, Day, Year)
350.310	Beating	PO	non	, 12	1.1.	D16492		► Oce	c. 14/994
30. NAM	P. DIZON, M.D.,	ST. JOSEPH	H MEDICA			7640 YOR	K RD., TOWS	ON, MD 2	1204
	E FILED (Month, Day, Year)	· Marting							
I DE	C1 6 1994 July	V britisian .	7711						

RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with ours after death. Page 6 may be immined by the page 10 miles claim.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page a moon to emission may be more frame to make the page 1, 2, 3 should	of Health and Mental Hygiene prior to burial, cremation, or removal.	chave any injury or other fraumatic event the medical examines much he mail the medical examines much he
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the de	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the a	be filed within 72 hours after death with the State Dept. of Health and Men	IMPORTANT: If item 29 to morked or item 22 chouse any inter-

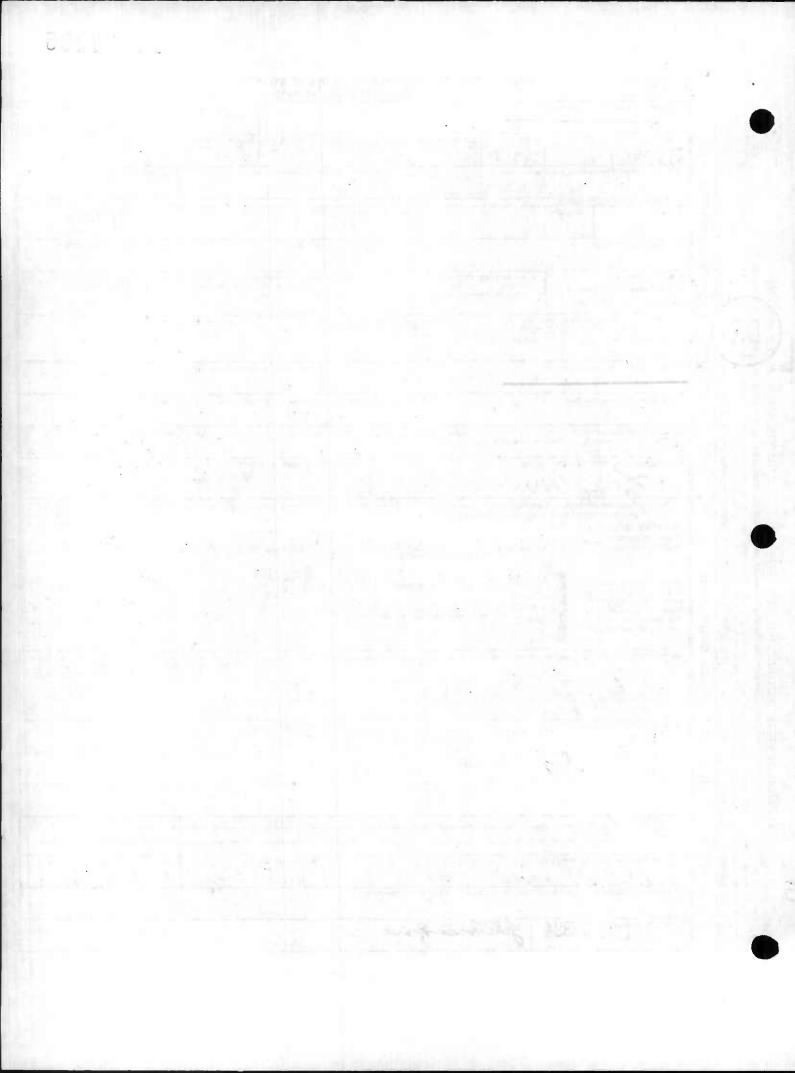
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH

1. DECEDENT'S NAME (First, Middle, Lest)

2. DATE OF DEATH

REGISTRAN			ENTIFIC	MIE	JE DEA		REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)	2TIS 0	ra Lee Cu	urtis				2. DATE OF DEATH DATE OF DATE OF DEATH DATE OF DEATH DATE OF DAT	a d	YEAR 3.	TIME OF DEATH
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I		F UNDER 1 YE	AR IF UND	R 24 HRS.	7. DATE OF BIRTH		6. BIRTHPI	ACE (State or Foreign
218056938 90. FACILITY NAME (If not institution, give	1 🗌 M 2 💢 F	91	YRS.	ONTHS DA	YS HOURS	MIN.	April 30	190	3 Vi	ginia
Church Home Ho					wn or local 1time		EATH	9c. COUN	N/A	Н
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	v		10-0174	TOWN OR L						
Maryland 1	N/A			1tim						d. INSIDE CITY LIMITS? YES 2 NO
3017 Baker St	reet				10f. ZIP COI 2121				USA	T COUNTRY?
11. MARITAL STATUS 1 Never Merried XX Merried 3 Widowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES 2X	ARMED NO	It ye	DECENDENT s, specify Cub YES 2 NO	an, Mexic	an, Puerto Rican, etc.)	or No—	Black, V	American Indian, Initia, atc.
15. DECEDENT'S EDU (Specify only highest grade			DECEDENT'S US	rk done durin		ting	16b. KIND OF BUS	SINESS/INDI	USTRY	
5th grade	College (1-4 or 5	+)	mesti		rker		1107.3			
17. FATHER'S NAME (First, Middle, Lest)						THER'S N	AME (First, Middle, Maiden	Sumame)		
-Robert Allen	Epps- Jo	hn Allen	Epps				E. Epps			
19e. INFORMANT'S NAME (Type/Print)							Route Number, City or Tow			21223
Nathaniel Har	ris		2211	W. S	arato	oga	Street Ba		more	, Maryla
20s. METHOD OF DISPOSITION 1 M Burtal 2 Cremetion 3 Ren 4 Donation 5 Other (Specify)	novel from State	20b. PLAC cemetery, of Arbu	EANDDATEOF	DISPOSITIO Piace) EMOr	N(Name of	Park	12% 16 /94°	cation — cutus	Maj	sum vland
21. SIGNATURE OF FUNERAL SERVICE LA	CSÁSEE			7	E AND ADDR					stown Ro
Gerry 9	Erris			Cha	tman-	-Har	ris F/H	Balt:	imor	stown Ro ≥,Md2121
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b. CULO DUE TO C. CONTO	UMM (OR AS A CONS	MUT EQUENCE OF):				DISEAS			
CAUSE (Disease or Injury that Initiated events resulting in death) LAST	DUE TO	(OR AS A CONS	EOVENCE OF):							
PART II. Other significant condition	ns contributing to	death but not	resulting in	the under	lying cause	given ir				RE AUTOPSY FINDINGS
MULTISMIKE	I DEM	ENTU	9				PERFOR	/	CO	AILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
25. WAS CASE REFERRED TO MEDICAL				2	6. PLACE OF	OEATH (C	heck only one)			
1 YES 2 NO	HOSPITAL:	ER/Outpetient		THER:	Home 5 🗆 s	Realdens	8 Other (Specify)			
27. MANNER OF DEATH 1 Neturel 5 Pending	28e. DATE OF (Month, D	INJURY	28b. TIME (OF 280	INJURY AT WORK?		28d, OESCRIBE HOW I	NJURY OCC	URED	
2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE C building.	OF INJURY — At I	home, term, str				28f. LOCATION (Street a City or Town, State)	and Number	or Hural Floui	e Number,
onel _							a to the cause(s) end mer e time, date end place, en			nd manner es stated.
29b. SIGNATURE AND TITLE OF CERTUFIE 30, NAME AND ADDRESS OF PERSON WITH	MINN	M)	EM 27 (5 1)	of mel	29c. LH	ENSE NU	MBER 135	29d. DATE	SIGNEO (M	orth, Day, Year)
ADDITED OF PERSON WI	COMPLETED GAU	S. OF DEALT (II	47) (1970), P	nn)						



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0 DIVISION OF VITAL BECODE

PHYSICIAN: MEDICAL CERTIFICATION

В

COMPLETED

BE

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CONTRACTOR OF THE PERCONDS, T.O. BOX 601 601	BALLIMONE, MARILAND ZIZIS-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Extrous after death. Page 6 may be retained by the hospital or attending physician.	hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filled within 72 hours after death with the State Oept, of Health and Mental Hygiene prior to burial, cremation, or removal.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunal, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	medical examiner must be notified at once.

94 37286 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH Τ. 5100 P. H DONNELL CUNNINGHAM DEC 994 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year, SEPT, 17. IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 38 1 X M 2 - F 14-78-02 SEPT MAR 9e. FACILITY NAME (If not institution, give street 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 1010 A RGVLF DIRECTOR NIA BALTIMORE 10e STATE 10b COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? BALTIMORE MARVLAND 1 YES 2 NO FUNERAL 10a. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21201 ERRV USA, WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 PNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE - American Indian, Black, White, etc. It yee, specify Cube 1 Never Merried 2 Merried ВҰ Specify Specify: 3 Widowed 4 Divorced BL COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementery/Secondary (0-12) College (1-4 or 5 +) 10+4 GRADE UNEMPLOYED 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First Middle Maiden St TANIE CUNNINGHAM BE 19e. INFORMANT'S NAME (Type/Print) 2 RGINIA CUNNINGHAM MULBERRY ST, BALTIMORE, MO. 20e. METHOD OF DISPOSITION
1 Burlel 2 Cremetion 3 Ren
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State 12-16-94 BALTIMORE, MD OREMATORY OF FUNERAL SERVICE LICENSEE 22. NAME AND APDRESS OF FACILITY JOSEPH H. BROWN JR FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD.21223 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ehock, or heert fallure. List only one ceuse on eech line. interval Batween **IMMEDIATE CAUSE (Final** Onset and Death HN INFECTION diseese or condition GO) WYOR resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF) Sequentielly ilst conditions, DUE TO (OR AS A CONSEQUENCE OF): if eny, leading to immediate cause. Enter UNDERLYING **CAUSE** (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST PART II. Other significent conditions contributing to death but not reculting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24a, WAS AN AUTOPSY OF DEATH?

WAS CASE REFERRED TO MEDICAL	26. PLACE	OF DEATH (Check on	ly one)		
1 VES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3	DOA 4 Nursin	g Home S Reeldence	8 Other (Specify)	
MANNER OF DEATH 1 Natural 5 Pending Investigation	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	5c. INJURY AT WORK? 1 YES 2 NO	26d. DEŞCRIBE HOW INJURY OCCURED	
Suicide 6 Could not be determined	28e. PLACE OF INJURY — At hombuilding, etc. (Specify)	ne, term, atreet, fector	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

MEDICAL EXAMINER: On the basis of exemination end/or investigation, in	n my opinion, death occured at the time, date and	
Softrat of controller	D 3977 \	29d. DATE SIGNED (Month, Day, Year)

S OF PERSON WHO COMPLETED CAUSE OF DEATH (IT

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► 12-14-94

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STATE OF MAR	YLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH	MENTAL HYGIENE REG. NO.
Ε.	CARY	2. DATE OF DEATH MONTH DAY

	1 - FOR STATE REGISTRAR	STATE OF MARYL		NT OF HEALTH AND TE OF DEATH	MENTAL HYGIEN	_				
	1. DECEDENT'S NAME (First, Middle, Last)	_			2. DATE OF DEATH		3. TIME OF DEATH			
	JAMES	E .		CARY	DEC 11	1994	11:37P M			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE		DER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8. BIRT	HPLACE (State or Foreign			
	219-62-6378	1 X M 2 🗆 F	37 YRS. MONTH	DAYS HOURS MIN.	(Month, Day, Year)	7517 ML	DUI AND			
	9e. FACILITY NAME (If not institution, give stre	et end number)	9b. C	TY, TOWN OR LOCATION OF C	EATH	9c. COUNTY OF	DEATH			
JOHNS HOPKINS HOSPITAL Baltimore City. N/A										
	RESIDENCE OF DECEDENT									
	106. STATE 106. COUNTY	61/6			al _ 1		16d, INSIDE CITY LIMITS?			
	MARYLAND	NA	В	ALTIMORE	CITY		1 YES 2 NO			
	10e. STREET AND NUMBER	1	ano.	101. ZIP CODE	4.0		WHAT COUNTRY?			
6 N. MT. OLIVET LANE 2/229 USA: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American Indian, Black, White, etc.)										
										3 Widowed 4 Divorced
	15. DECEDENT'S EDUCA	TION	180. DECEDENT'S USUAL	OCCUPATION .	Lan www on au	134	ACK			
	(Specify only highest grade of	ompleted)		ne during most of working	168. KIND OF BU	SINESS/INDUSTRY				
	Elementary/Secondary (0-12)	College (1-4 or 5+)		PROVEMENT	SELF	=- EMPL	NIFO			
	17. FATHER'S NAME (First, Middle, Last)	465	THE TIME		AME (First, Middle, Meiden		wy-L			
	ROGER		CARV	ANNIE			1			
	19a, INFORMANT'S NAME (Type/Print)		01.	ESS (Street and Number or Rural		THOMA	13			
		ARY	LONI MT				Mh 1/060			
			PLACEAND DATE OF DISF	DLIVET LF	THE BALL	TIMORE	MD, 2/229.			
١	20s METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remove 4 Donetion 5 Other (Specify)	1 1	netery, crematory or other pla-	767						
	21. SIGNATURE OF FUNERAL BERVICE LICE		SUDON PAI	2. NAME AND ADDRESS OF F	12-16-94 E	PALTIMO	RE, MD,			
ĺ	(((a. ()			JOSEPH H. BRO		RAL HOME	,P.A.			
	Tona	-016		1913 W. BALT						
	23. PART i. Enter the diseases, or co	mplications that cause	d the desth. Do not an	er the moda of dying, su	ch ss cardisc or resp	iratory arrest,	Approximate			
	shock, or hasrt failure. Li iMMEDIATE CAUSE (Final	st only one cause on e	esch iina.				Interval Batween Onset and Death			
	disesse or condition resulting in death)	Multipl	le Gun	shot woun	ÁS		į			
	a.	DUE TO (OR AS	A CONSEQUENCE OF):	0000						
	C b									
	Sequentially list conditions, if sny, leading to immediata	OUE TO (OR AS	A CONSEQUENCE OF):							
	CAUSE (Disease or Injury									
	that initiated events	DUE TO (OR AS	CONSEQUENCE OF):							
	resulting in dasth) LAST d.									
١	PART ii. Other significant conditions	contributing to death b	out not resulting in the	underlying cause given in	Part I. 24a. WAS AN	AUTOREV 24	o. WERE AUTOPSY FINDINGS			
۱		The second second	The state of the s	ondariying cause givan ii	PERFO		AVAILABLE PRIOR TO			
Ì					TYPES :	□ NO	OF DEATH?			
Ì	5.5 -5.5					- 1	1 PYES 2 NO			
	DID TOBACCO USE CONTRI	BUTE TO CAUSE C			N D					
1		HOSPITAL:	26. PLACE OF DEATH (Che							
		Inpetient 2 - ER/Out	patient 3 DOA 4 D	lursing Home 5 - Residence	6 Other (Specify)					
	27. MANNER OF OEATH	(Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK7	28d. OESCRIBE HOW	NJURY OCCUREO				
1		2 Accident Investigation 12-11-94 2027 11 TES 2 SINO 765, EEV Shoh								
	t Natural 5 Pending 2 Accident Investigation				143,000	3.0.				
ı	2 Accident Investigation 3 Suicide 8 Could not be		— At home, ferm, street, f	actory, office	28f. LOCATION (Street City or Town, State)	and Number or Rural	Route Number.			
	2 Accident Investigation 3 Suicide 8 Could not be determined	28e. PLACE OF INJURY	- At home, ferm, street, f	actory, office	28f. LOCATION (Street City or Town, State)	and Number or Rural	Route Number. 13allymene			
1	2 Accident 3 Suicide 4 Could not be datermined 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICI.	28e. PLACE OF INJURY building, etc. (Special Special ome, ferm, street, f Street	e time, date end place, end du	City or Town, State;	NI. Chap	Ballinere				
	2 Accident 3 Suicide 4 Could not be datermined 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICI.	28e. PLACE OF INJURY building, etc. (Special Special ome, ferm, street, f Street		City or Town, State;	NI. Chap	Ballinere				
	2 Accident 3 Suicide 4 Could not be datermined 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICI.	28e. PLACE OF INJURY building, etc. (Special Special ome, ferm, street, f Street	e time, date end place, end du	City or Yown, State;	N. Chap mor ee stated. id due to the couse	Ballinere				
	2 Accident 3 Suicide 4 Could not be determined 29e. CERTIFIER (Check only one) 22 MEDICAL EXAMINER:	28e. PLACE OF INJURY building, etc. (Special Special ome, ferm, street, f Street	e time, date end place, end du y opinion, death occured at the	City or Town, State,	nner se stated. Id due to the couse(e) end menner ee stated.				
	2 Accident 3 Suicide 4 Could not be determined 29e. CERTIFIER (Check only one) 22 MEDICAL EXAMINER:	28e. PLACE OF INJURY building, etc. (Special Programme) and the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of exemination of the basis of the	T — At home, ferm, street, f	e time, date end place, end du y opinion, death occured at the 29c. LICENSE NU	City or Town, State,	nner se stated. Id due to the couse(e) end menner ee stated.			
	2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 22 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIEB 30. NAME AND ADDRESS OF PERSON WHO	AN: To the best of my know On the basis of exeminatio	r — At home, ferm, street, for the course of	e time, date end place, end du y opinion, death occured at the 29c. LICENSE NU O • C • M	city or Town, State,	nner ee stated. Id due to the couse(29d. DATE SIGNET	e) and manner so stated. O (Morth, Day, Year) 2, 1994			
	2 Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 22 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIEB	AN: To the best of my know On the basis of exeminatio	r — At home, ferm, street, for the course of	e time, date end place, end du y opinion, death occured at the 29c. LICENSE NU	city or Town, State,	nner ee stated. Id due to the couse(29d. DATE SIGNET	e) and manner so stated. O (Morth, Day, Year) 2, 1994			

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS. P.O. BOX 68760.

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	ILIAN: The law requires that the death certificate be executed within 24 hours after death. Page
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portable. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

The law requires has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

The medical examiner must be notified at once. TO THE HOSPITAL DIFFER TO THE FUNERAL DIFFER THE FILE WITHIN 72 INTERMEDIATE IN THE POPTIANY: If I INTERMEDIATE IF

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR				CE		CATE O		EATH	MENTA	REG. NO			
1. DECEDENT'S NAME (First	, Middle, Last)									OF DEATH			3. TIME OF DEATH
Alison Nisbet Allan Duncan			can				Dec 10, 1992			94	5:55a M		
4. SOCIAL SECURITY NUME		5. SEX		in yrs. last		IF UNDER 1 YEA	R IFU	INDER 24 HRS.		OF BIRTH			IPLACE (State or Foreign
219-86-6346		1 M 2 F		87	YRS.	ONTHS DAY	8 HOU	JRS MIN.	(Mont	h, Day, Year)	1007	Countr	γ)
BEL AIT COT		cent Cent	er 1	.nc.		В	el A	Air			1	Harfo	ord
10e. STATE	10b. COUNTY	,			10c. CITY.	TOWN OR LO	CATION						10d. INSIDE CITY
Maryland	Rol1	imore				Parkt	0.00						LIMITS?
10e. STREET AND NUMBER	Dai	THOTE				Tarkt		CODE			40. 017		1 TYES 2 NO
109. CITIZEN OF WHAT COUNTRY? 18912 Middletown Road USA													
11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN	U.S. ARI	MED			NT OF HISPAN			s or No-	14. RACE	- American Indien,
1 Never Merried 2 3 Widowed 4 Divo		FORCES? 1			0			Cuben, Mexica NO Specify		Rican, etc.)		Speci	c, White, etc.
15. DEC	EDENT'S EDU	CATION		18e. DEC	CEDENT'S U	SUAL OCCUPA	ATION	_	166	. KIND OF BU	SINESS/INI	DUSTRY	***************************************
(Specify only Elementary/Secondary (0	y highest grade	College [1-4 or 5		(Gh	ve kind of wo Do NOT use	ork done during	most of w	vorking	100				
E-initially occordary (c	, 12,	3	" [ŀ	lomem	aker				Ow	n Hoi	ne	
17. FATHER'S NAME (First, M	liddle, Last)						18.1	MOTHER'S NA	ME /First				
unknown b	v info	rmant					10.		imic (1 mai,	Milutio, Martieri	Surrianne)	A 1	11.00
190. INFORMANT'S NAME (7		Timatre	_	401				Mary					llan
Mrs. Jennif		Stalfort	:					mber or Aurel F vn Road				,	nd 21120
20e. METHOD OF DISPOSIT	ION					DISPOSITION					CATION —		
1 Donetter 5 Other		oval from State	cem Me	etary, cren	Crem.	er place) atory			De	2	tons		
21. SIGNATURE OF FUNERA		DENYS (I)			OZ OM		ANO AD	ORESS OF FA		<u> </u>	COMS	/ 1116	., 110
Bryan W	Clar	Wary	1	7				Funera Padonia			moni	ım 1	4D 21093
23. PART I. Enter the di	_		aused	the dea	ath. Do no	t antar tha	moda of	dving, auci	h aa can	diac or read	iratory ar	rest.	Approximate
IMMEDIATE CAUSE (Fir disease or condition resulting in death)	aart fallura.	List only one cau	on as	ach Ilna.	is						,	,	Interval Batween Onset and Death
		OUE TO	OR AS	CONSEO	UENCE OF)								
Sequantially list conditi		b											
if any, leading to imme-	diata	DUE TO	(OR AS A	CONSEO	UENCE OF)								
cause. Entar UNDERLYI CAUSE (Disease or inju		c			_								
that initiated eventa resulting in death) LAS		DUE TO	(OR AS A	CONSEO	UENCE OF)								
resulting in death) LAS	' (d											
PART II. Other algolfica	nt condition	a contributing to	death h	ut not ce	auitino in	the underly	dna cau	ina aluan in	Dort I	24s. WAS AN	ALITOROV	1 24	
- 6	Lake	muis	de			rae underly	ying cau	ise given in	Part I.	PERFO		246.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
	7/0	ne La		- Marca	31				-	1 TYES	NO X		OF DEATH?
													1 TYES 2 NO
DID TOBACCO U		RIBUTE TO CA	USE O	F DEAT	TH YES	NO D	Ø U	NCERTAIN	N 🗆				(4
25. WAS CASE REFERRED TO EXAMINER?	D MEDICAL	HOSPITAL:		26. PLACE		(Check only o	ne)						
1 TES 2 XNO		1 Inpetient 2	ER/Outp	etient 3		OTHER: Nursing H	lome 5	Reeldence	8 🗆 Othe	r (Specily)			
27. MANNER OF DEATH		28e. DATE OF (Month, D			285. TIME INJU	OF 28c.	INJURY A		_	SCRIBE HOW	NJURY OC	CURED	
	Pending Investigation	(MORII, D	ay, reer)		INJU		WORK?	2 NO					
28e PLACE OF INJURY — At home term street testory office													
Suicide 8 Could not be determined building, etc. (Specify) building, etc. (Specify) City or Town, State)													
29e. CERTIFIER													
CERTIFIER (Check only One) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner ea stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)													
1	2	-					-						-9 4
38. NAME AND ADDRESS OF	PERSON WH	O COMPLETED CALL	SE OF OF	ATH HTEM	127) /kma /	Print)	-	346	, _				1/
S. Hasw		2 N.	AV	2	Suit	2 /01		BILA	11 .	MD	211	114	
DECT 6	94 4	32. REGISTRA	R'S SON	dall								/	

3. TIME OF DEATH

10d. INSIDE CITY LIMITS?

1 X YES 2 | NO

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AVAILABLE PRIOR TO COMPLETION DF CAUSE

1 YES 2 NO

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BAUT MD 21227

Approximate interval Between

Onset and Death

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

WILLIAM 31. DATE FILED (Month, Day, Year)
DEC1 6 1994

1994

FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH YEAR LORRAINE ROSE DONAHUE DECEMBER 1994 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year) NOV. 2, 1930 #F UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) 218-26-2743 1 M 2 X F 64 YRS. MARYLAND Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ST. AGNES HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION MARYLAND BALTIMROE use as the burial-transit permit. FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2126 HARMAN AVENUE 21230 U.S.A. or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES ZX NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried ВУ Specify: 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) director, page 5 should be detached for College (1-4 or 5+) retained by the hospital 11TH GRADE DISTRIBUTATION CLOTHING STORE once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Ħ EDWARD PETTIE ROSEMOND BARLOW BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 CLARENCE M. DONAHUE 2126 HARMAN AVENUE - BALTIMORE, MD 21230 2 eq 20a. METHOD OF DISPOSITION
1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Removal from State nours after death. Page 6 may 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State 1 N Buriel 2 Cremation 4 Donation 5 Other (Specify) must LOUDON PARK MAUSOLEUM 12/17 BALTIMORE examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY the funeral HUBBARD FUNERAL HOME INC 4107 WILKENS AVENUE-BALTIMORE, MD or removal. medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart failure. List only one cause on each line. filled in by IMMEDIATE CAUSE (Finel cremation. or other traumatic event, the disease or condition_ athersellerotic . Hy pertensive completely resulting in death) executed within DUE TO (OR AS A CONSEQUENCE OF): signed by the attending physician and com-Health and Mental Hygiene prior to burial, Due to (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS MEDICAL 1 TYES 2 WAND has been signer bett, of Health n 23 shows a PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? item / 26. PLACE OF OEATH (Check only one) State certificate HOSPITAL: / Impetient 2 Hospital 3 DOA OTHER: 4 - Nursing Home 5 - Residence 6 - Other (Specify) 6 the 27. MANNER OF GEATH 26e. DATE OF INJURY (Month, Day, Year) marked, 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this with 1 Natural 5 Pending Investigation 1 YES 2 NO BY After death 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 99 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A bours after d COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER

(Chack only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) and menner es attend. FUNERAL (MPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner ee stated. BE 29d. DATE SIGNED (Month, Day, Year) 불물을 3018 2 8 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CRUSE OF DEATH (ITEM 27) (Type, Print)

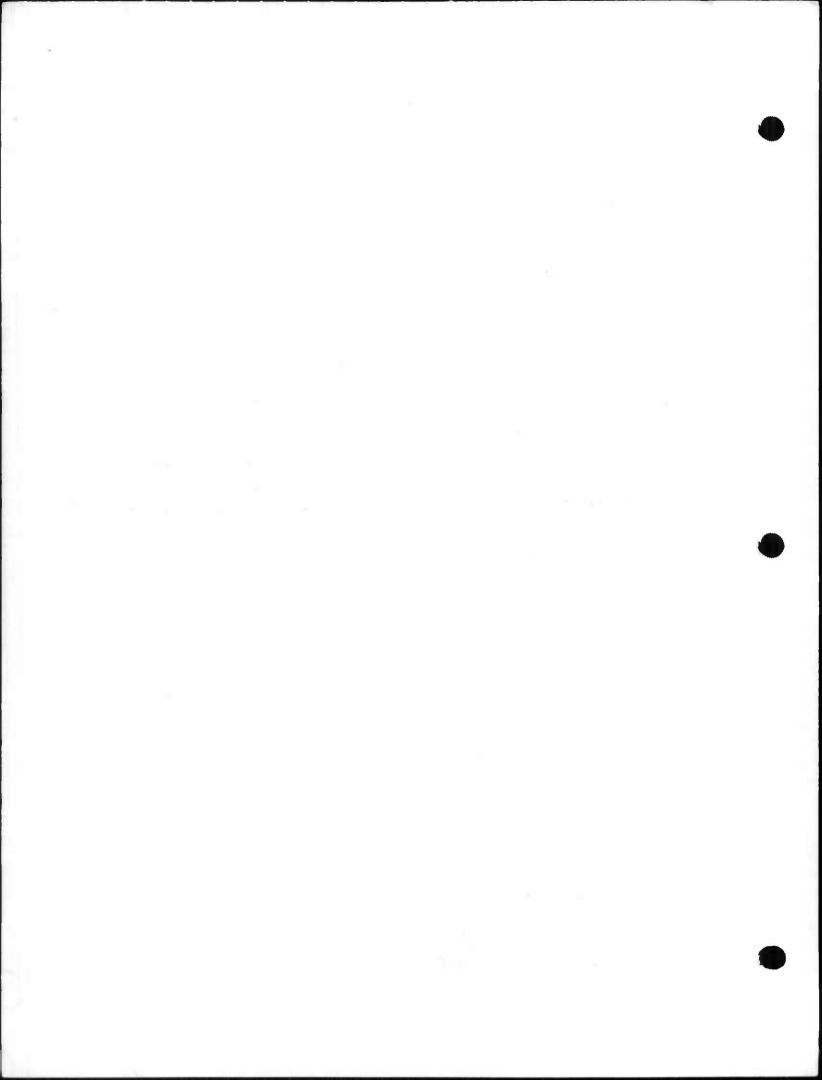
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BENJON

3320

32. REGISTRAR'S SIGNATURE

Saudjor Radal



BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an hours after death. Page 6 may be retained by the hospital or attending physician.

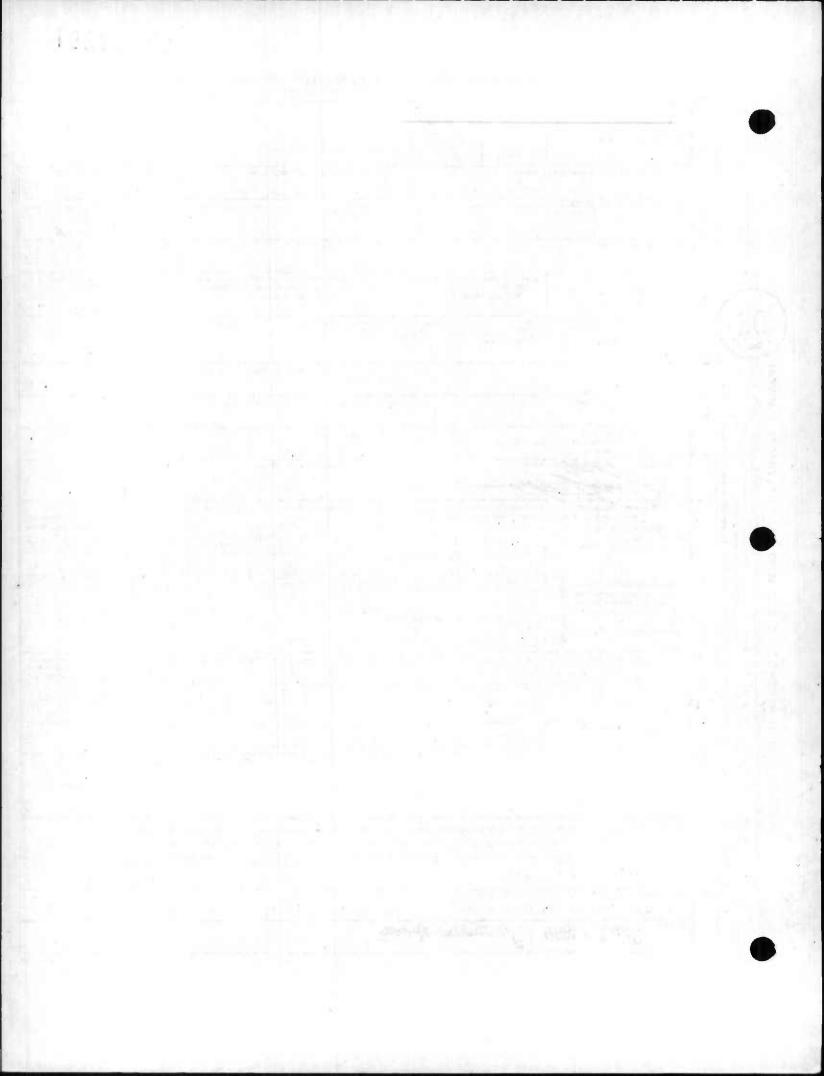
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

_		REGISTRAR			CE	RTIF	ICATE O	F DEATI	H	R	EG. NO.			
	ì	1. DECEDENT'S NAME (First, Min	ddle, Last)							2. DATE OF I	DEATH			3. TIME OF DEATH
	Ĭ	IRENE	A.	DILWORT	H					HTHOM -	12	- 0	YEAR	235 AM
	ı	4. SOCIAL SECURITY NUMBER			(In yrs. last	birthday)	IF UNDER 1 YEA	IF UNDER 24	HRS.	7. DATE OF B	ивтн 1-	22-24	6. BIRT	HPLACE (State or Foreign
	i	213200121		1 🗆 M 2 📉 F	70	YRS.	MONTHS DAY	HOURS	MIN.	(Month, De		4	Coun	(ny)
	ŀ	9a. FACILITY NAME (If not institu		/-			Ob CITY TOW	N OR LOCATION	1.05.054					MORE, MARYLAND
000		1 16		Store "1 1						ин			INTY OF I	
2		RESIDENCE OF DECE	aritan	Hospital			Da	Homore				BALT	IMORE	CITY
DIRECTOR	ŀ		b. COUNTY			10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY
<u> </u>	ı	MARYLAND	RAI TTM	ORE CITY	i	BALTIMORE								LIMITS?
	- 18-	10e. STREET AND NUMBER	DALIDA	DIE OIT										1 X YES 2 NO
NA.							101. ZIP CODE					10g. CIT	IZEN OF	WHAT COUNTRY?
ÿ	1	6104 EVERALL AVENUE					21206					US	iA	
FUNERAL	I	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U. 1 Never Married 2 X Married FORCES? 1 YES 2						ECENOENT OF specify Cuban,				or No-	14. RAC	E — American Indian, ik, White, atc.
BY	- 41	3 Widowed 4 Divorce	DATES			ES 2 NO		, roanto nicar	1, 016.)		Spec	elfy:		
	- 11	15. DECEDENT'S EDUCATION 154												WHITE
once. COMPLETED	ı	(Specify only highest grade completed)					USUAL OCCUPA			16b. KIN	O OF BUS	SINESS/IN	DUSTRY	
l iii		Elementary/Secondary (0-12) College (1-4 or 5 +)					e retired.)			1				
2 D	I.	10 HO					}			HOUS	EKEEP	PING		
ᆲᅙ		17. FATHER'S NAME (First, Middle				18. MOTHE	R'S NAM	E (First, Middl	e, Maiden	Sumame)				
E m	Ш	CHARLES L. KESS	LER					GOLDI	E HAF	RVEY				
		19a. INFORMANT'S NAME (Type	/Print)		19b	MAILING	AOORESS (Stre	et and Number o	r Rural Ro	oute Number, C	ity or Tow	n, State, Zi	p Code)	
1 2	1	FRANCIS D. DILW	ORTH SE	3.	1 6	3104 E	VERALL A	VENUE BA	MITIM	ORF. MA	RYI AN	D 212	06	
2	ı	209. METHOD OF DISPOSITION		20			OF DISPOSITION			DATE				own, Stata
S	ı	1 A Buriel 2 Cremation 4 Donation 8 Other (Sp.		rel from State	metery, cren	natory or o	METHODIS	T CEM D	NEC 4	15 100/	BALT	TMODE	MAD	VI AND
examiner must be notified at once. TO BE COM	ľ	21. SIGNATURE OF FUNERAL S			UII UI	шш	22. NAME	ANO ADDRESS	OF FACE	LITY		TI-IOUL	11174	ITLAND
Ē	1	withour !					LASSA	HN FUNEF	PAL HO	OME, IN	C.			
	1	LASSAHN FUNERAL HOME, INC. 7401 BELAIR ROAD BALTIMORE, MARYLAND 21236												
8		23. PART I. Enter the dise	asea, or co	implications that cause	d the dea	th. Do r	ot enter tha	node of dyln	g, such	ss cardiac	or respi	ratory se	rest,	Approximate
Ē	l		t fallure. Li	ist only one cause on	aacn iina.								Onset and Death	
Ě	disease or condition										m/1			
event, the medical	disease or condition resulting in desth) s. Due to (pr as a consequence of):													
	TOUR									7100m				
or other traumatic ERTIFICATION	1	Sequentially list conditions, if any, leading to immediate our to log As A consequence of):												
E E	ļ	if any, leading to immediate cause. Enter UNDERLYING												
		CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):												
2 1	Ì	resulting in death) LAST												
5 5					/			/						
DICAL CE	1	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PERFORMED? PERFORMED? AMAILABLE PRIOR TO									b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
	1	OSE	0/10	nessi	100	mo	of Ki	in ho	ريموا	10	YES 2			COMPLETION OF CAUSE OF DEATH?
Shows	- 11	20h	6	wohn-							11.4			1 YES 2 NO
5 5	- 11									_				
N A	ļ	25. WAS CASE REFERRED TO M	IEDICAL				28	PLACE OF DEA	ATH (Chec	k only one)				
PHYSICIAN		EXAMINER?		HOSPITAL:	footlant 1	D DOA	OTHER:				14 -1			
ž į		27. MANNER OF DEATH		28a, DATE OF INJURY	-Ferrett 2	28b, TIM		ome 5 Resi	-	28d. OESCRII		N.HIBY C	CHIDEO	
By PHY	1	1 Natural 5 Per		(Month, Day, Year)	1		URY	WORK?		LOU. VEŞUMI	L HOW I	HOURT OC	CONED	
5 m	A.	Accident Inve	estigation	28s. PLACE OF INJUR	V At hos						A1 (O+ - 1			
1 2	Н	3 COL	uid not be ermined	building, etc. (Sp.	ecify)	no, curring	interest, factory, o	ilco	1		wn, State)		W OF PIURE!	Route Number,
E	1	CERTIFIER												
AP I	T	(Check only		AN: To the best of my kno										
D BE COMPLE		2 MEDICAL	EXAMINER	On the basis of examinati	on and/or Ir	weatigatio	n, in my opinio	, death occured	d at the ti	me, data and	place, an	d dua to t	he cause(a) and manner as stated.
BEC	1	296. SIGNATURE AND STEE OF	CENTIFIER	22/17				29c. LICEN	SE NUMB	BER		29d. DA	TE SIGNE	(Mghth, Day, Year)
E 0	Æ	1/1am	1/10	1//2	0			PA	76	193		> /	12	112/94
<u>ا</u> =	T	30. NAME AND ADORESS OF PE	ERSON WHO	COMPLETED CAUSE OF O	EATH (ITEM	27) (Type	Print)						7	
		31. DATE FILED (Month, Day, Year DEC16 1	004	37. REGISTRANG SIG	N PRE	M		-						
	- (1)	HELL IN I	774	James and and the state of the	A COLUMN									

DIVISION OF VITAL RECORDS, P.O. BOX 68760,	BALTIMORE, MARYLAND 21215-0020
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REGISTRAR		MARYLAND C		ICATE			WENT INC	REG. N			
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4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. In	ast birthday)	IF UNDER 1 1	YEAR IF	IF UNDER 24 HRS.	7. DATE O		13	94	HPLACE (State or Foreign
220-12-8050	1 🗆 M 2 😾 F	95	YRS.	T		IOURS MIN.	(Month, May	Day, Year)	399	Ire	(ערו
Sa. FACILITY NAME (If not institution, give	street and number)			9b. CITY, T	OWN OR L	LOCATION OF DE	EATH		9c. CO	UNTY OF E	DEATH
Bel Forest Nursi	ng & Reha	b. Cent	er	Fore	est H	Hill, M	D		Har	ford	
	Harford					Jarrettsville					10d. INSIDE CITY LIMITS? 1 YES 2 NO
10a. STREET AND NUMBER 10f. ZIP CODE									10g. CI	TIZEN OF	WHAT COUNTRY?
2204 Nodleigh Te	rrace				21	084-11	16		US	٨	
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED								(Specify V	-		F American Indian
1 Never Married 2 Merried 3 Widowed 4 Divorced	NO If yes, specify Cuban, Maxican,				n, Puarto Ri			Spec			
3 Widowed 4 Divorced IF YES, GIVE WAR OR C			ECEDENT'S	USUAL OCC	HIDATION		I ann 1	VIIID OF 5	USINESS/IN		nite
(Specify only highest grad	(0	Give kind of v	vork done dur	ring most of	of working	100. 1	MIND OF B	ValidE22/IP	DUSTRY		
Elementary/Secondary (0-12)		use retired.)				1					
12 Matron Baltimore County Ja: 17. FATNER'S NAME (First, Middle, Lest) Baltimore County Ja:									Jails		
Patrick Clarke					18		1112		100	171	
190. INFORMANT'S NAME (Type/Print)						Marga					
						Number or Rural					- 01001
Elizabeth H. Phij	pps										
Elizabeth H. Phipps 2204 Nodleigh Terrace, Jarrettsville, MD 21084 - 20a. METNOD OF DISPOSITION DATE 20c. LOCATION - City or Town, State 1116											
Vilson United Meth. Church Long Green, MD											
M. SIGNATURE OF EUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093										een,	_ F1D
Lower S. Y.	mmon o	2		22. NA	AME AND A	ADDRESS OF FA	al Ho	me			
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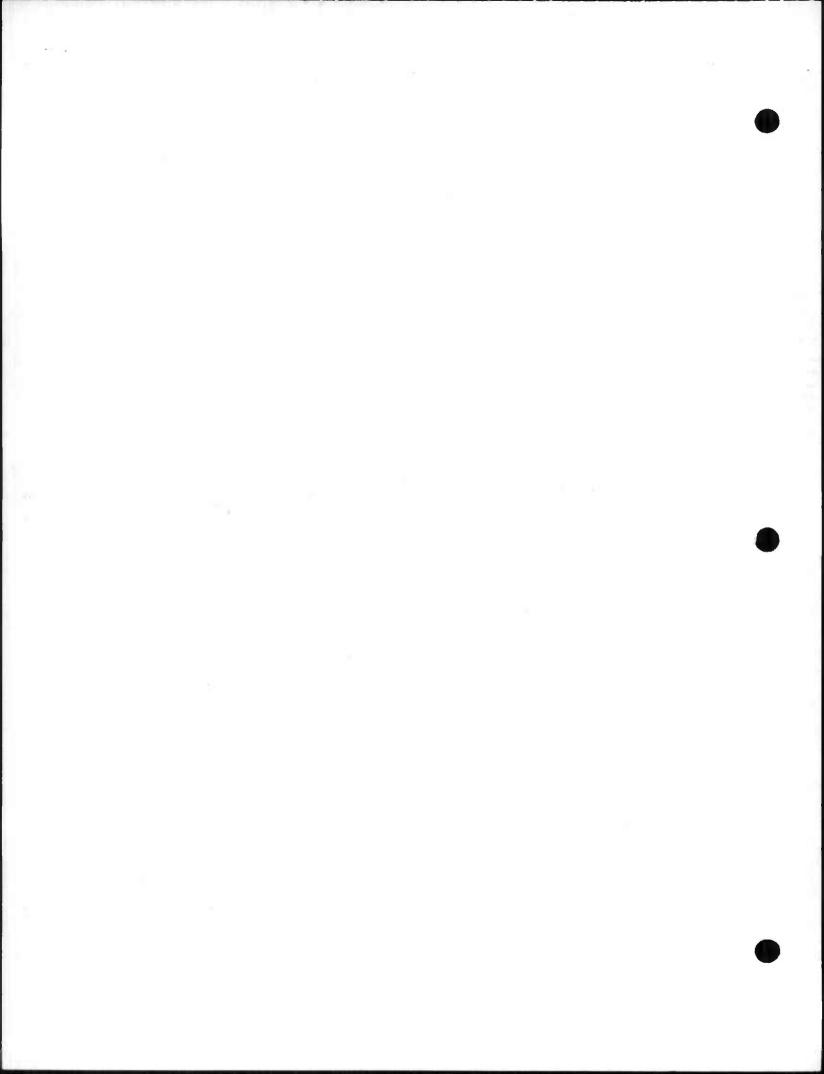
RAI TIMORE MARYI AND 21215-0020

DIVISION OF VITAL RECORDS P.O. BOX 68760

COLUMN CHE MAN LAND SIZIS-0020	NSICIAN: The law requires that the death certificate be executed within at hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	of any flower Of shares near inferent any other femiliars as any and for mentions messale has a matter at a man
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

	TICGIOTTAN				DEATH	FIL	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) BGBG BGW	Eleonu			-	2. DATE OF D	EATH DAY	3. TIME OF DEATH	D		
	4. SOCIAL SECURITY NUMBER 5. SEX	6. AGE (In yrs. In	st hirthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF B		8. BIRTHPLACE (State or Foreign			
	1 🔀 M			MONTHS DAY		(Month, Day		Country)	<u> </u>		
	9a. FACILITY NAME (If not institution, give street and nu	,			N OR LOCATION OF O	EATH	9c. COL	UNTY OF DEATH			
DIRECTOR	ST JUSEPH 16 RESIDENCE OF DECEDENT	SPITAL		1	Mosmo		B	ALT CO.	_		
E I	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d, INSIDE CITY				
							LIMITS? 1 VES 2				
FUNERAL	10e. STREET AND NUMBER				101. ZIP CODE		TIZEN OF WHAT COUNTRY?				
5	11. MARITAL STATUS 12. WAS I				NIC ORIGIN? (Sp	ecify Yea or No-	14. RACE — American indian,	\dashv			
BY F		CES? 1 YES 2 S S, GIVE WAR OR DATES	NO		specify Cuban, Maxica ES 2 NO Specif		, etc.)	Black, White, atc. Specify:			
	15. OECEDENT'S EDUCATION (Specify only highest grade completed)			SUAL OCCUPA		18b. KINI	OF BUSINESS/IN	DUSTRY			
PLET	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) (Give kind of work done during most of working life. Do NOT use refired.)										
COMPL	17. FATHER'S NAME (First, Middle, Last)	•••		18. MOTHER'S NA	ME (First, Middle	, Maiden Surname)		\neg			
BE	19a. INFORMANT'S NAME (Type/Print)	10	MAILING A	DDDESS /Com	et and Number or Rural	Bouto Alverbas Ci	hi in Faire Chall T	(- Control	\dashv		
2	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ou maichte	ODNESS (SIE	and number of note:	noute Number, Cr	ty or lown, State, 21	p Code)			
	20a, METHOD OF DISPOSITION 1	Stata cemetery, cr	ematory or oth			DATE		- City or Town, State	\neg		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		-	22. NAME	AND ADDRESS OF FA	CILITY ,	0 11. 4		\neg		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE St. Jeseph Me	edical Ces	nter	7	70 York	K Rd.	Tourse	-, MD 2120	4		
	shock, or heert fallure. List only	ions that ceused the d one cause on each lin	eeth. Do no e.	t enter tha i	node of dying, auc	h aa cardisc	or reapiratory ar	rrest, Approximate interval Betwee	een		
	disease or condition										
z	DUE TO (OR AS A CONSEQUENCE OF): CONSISTENT WITH GESTATIONAL AGE 22 CNEEKS!										
CERTIFICATION	if any, leading to immediate										
E C	CAUSE (Disease or injury										
E	that initiated events resulting in death) LAST OUE TO (OR AS A CONSEQUENCE OF): SPONTINE OF FETAL MEMBRANES d. SPONTINE OF FETAL MEMBRANES										
	PART ii. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 24s. WAS AN AUTOPSY FINDINGS										
EDICAL				and discour,	ing couse given in		PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
MED				-			1163 2 110	OF DEATH?			
	DID TOBACCO USE CONTRIBUTE	TO CAUSE OF DEA	ATH YES	□ NO	UNCERTAIL	N 🗆					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	26. PLA	CE OF DEATH	Check only or							
Sic	nose:	TAL: tlent 2 - ER/Oulpatiant :		OTHER: United Heading H	ome 5 🗆 Rasidenca	6 Other (Spe	clfy)				
ξI	~ 4	DATE OF INJURY (Month, Day, Year)	28b. TIME		NJURY AT WORK?	28d. DESCRIB	E HOW INJURY OF	CURED	\neg		
BY	1 Natural 5 Pending 2 Accident Investigation				YES 2 NO						
COMPLETED 8	3 Suicide 28a.	PLACE OF INJURY — At he building, aic. (Specify)	ome, farm, st	reet, factory, of	fica	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
۳	29a. CERTIFIER CERTIFYING PHYSICIAN: To the	na beat of my knowledge, d	agth occurred	et the time d	ets and place, and due	to the course(s)	and manner as at		\neg		
M	(Check only one) 2 MEDICAL EXAMINER: On the b								a.		
	29b. SIGNATURE, AND TITLE OF CERTIFIER								_		
BE	ten 1 He MD PATHOZOGIST 034543 11-23-94										
유	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
	STEVEN RAXE MD ST JOSEPH HOSPITM, TOWSON, MD 21204 31. DATE FILED (MORITIN, Day, Year) 32. AFGISTRAR'S SIGNATURE										
- 1	31. DATE FILED (Month, Day, Your) 32. REGISTRAR'S SIGNATURE DF C 1 7 1994 July Development										



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, MARYLAND 21215-0020	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF M		DEPAR					MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last)	Paul F	Keithan	Edwa	rds	1			MONT	e of DEATH DA		YEAR 1994	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 183-05-8761	5. SEX	6. AGE (In yrs. In:	st birthday) YRS,	IF UNDER	1 YEAR DAYS	IF UNDER	24 HRS. MIN.	7. DATE	of BIRTH		s. BIRTNE Country	LACE (State or Foreign
	9n. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH						-	
CTOR	2920 Salisbury A	venue		Edgemere						Ba	ltimo	ore	
DIRECTOR	Maryland 10b. COUNTY	Baltin	ore	10c. CITY, TOWN OR LOCATION				gemere			- 1	10d. INSIDE CITY LIMITS? 1 YES 2 X NO	
FUNERAL	10e. STREET AND NUMBER			101	ZIP COD		10g. CITIZEN OF W			IZEN OF WI	NAT COUNTRY?		
NE I	2920 Salisbury A								1219			ited	States
	11. MARITAL STATUS 1 Never Married 2 Married		YES 2			If yes, sp	ecify Cuba	n, Mexica	n, Puerto	N? (Specify Yea Rican, stc.)	or No-	14. RACE Black,	- American Indian, White, etc.
B	X ⊠ Widowed 4 □ Divorced	IF YES, GIVE W				1 U YES	2 100	Specify	y:			Specify	White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade	CATION completed)	(G	CEDENT'S	work done			ng -	160	b. KIND OF BUS			
PE	Elementary/Secondary (0-12)	College (1-4 or 5+) life	Mach		t			10	Manufa Manufa			
NO I	12 Years 17. FATHER'S NAME (First, Middle, Last)						18. MOTI	NER'S NA		Middle, Maiden			
BE C	Luther B. Edwards							mma		Jnknown			5
2	19a. INFORMANT'S NAME (Type/Print)		19							nber, City or Town			
-	Lavinia J. Mille	r						venu	_	Edgemer			219
	20a. METNOD OF DISPOSITION Disposition 3 Gramation 3 Remote 4 Donation 5 Gramation (Specify)	oval from State	20b. PLACE	AND DATE	OF DISPOS	m E	me of	2/16	DAT	Mid	- MOITAS	City or Tow	n, State
ı	21. SIGNATURE OF FUNDMAL SERVICE-LIC	ENSEE	INCLES	/ 1111	22.	NAME AN	D ADDRES	SS OF FA	CILITY				
-1	15A V	1								al Home Dundal			alk, Inc.
	23. PART I. Enter the disesses, or c	omplications that	ceused the de	ath. Do	not snter	1922 the mo	de of dyl	ng, auci	h as car	DUNCAL diec or respir	ratory an	rest.	and 21222
	shock, or heert fellure. List Dnly one ceuse on esch iine. iMMEDIATE CAUSE (Finel Onset and Dasth												
	immediate cause (Finel disease or condition resulting in death) a. Congestive Heart Failure Due to (OR AS A CONSEQUENCE OF):									145.			
NO	Sequentially list conditions,	Chronic	Reval	Fai	lure								lyr.
AT							1000	100	No	00.00			Surs
E	rier minered exelice	Athero o						,	1,20	2002			3412
CERTIFICATION	resulting in death) LAST	Renal	ceil	Car	rin	DMC	1						140.
_	PART II. Other significant conditions	s contributing to	desth but not	resulting	In the ur	derlying	ceuss (lven in	Part i.	24s. WAS AN	AUTOPSY MED?		WERE AUTOPSY FINDINGS
DIC.	FAMENDAMA - <		Rows							1 TYES 2			COMPLETION OF CAUSE DF DEATH?
ME	though Depen		liabetes		-					-			1 YES 2 NO
AN	DID TOBACCO USE CONTR	RIBUTE TO CA		TH YE	S		UNC	ERTAIN	1 1				
SICI	EXAMINER?	HOSPITAL:			OTHER	3:	s R md	aldanaa	8 D Otto	er (Specify)			
PHYSICIAN: MEDICA	27. MANNER OF DEATN	28a. DATE OF (Month, Da	INJURY	28b. TIM		28c. INJ				SCRIBE HOW IN	JURY OC	CURED	
BY	1 Nstural 5 Pending 2 Accident Investigation				M	1 🗆 1	'ES 2 [NO					
	3 Suicide 8 Could not be 4 Nomicide detarmined	26e. PLACE Of building,	FINJURY — At ho etc. (Specify)	ome, ferm,	street, fact	ory, office			28f. LOC City	CATION (Street a or Town, State)	nd Number	or Rural Ro	ute Number,
COMPLETED		CIAN: To the best of											
20h SIONATHEE AND TITLE OF CERTICIES													
) BE	296. SIONATURE AND TITLE OF CERTIFIER 296. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 12/14/194												
임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEATH (ITE	M 27) (Type	Print)	7	01	0	4.1				1
	11 DATE ELLED MONTH OF THE	+ Y. 7	shell	vort	7 604	1	14	くり	alt	more	W	1) 3	1219
	31. DATE FILED (Month, Day, Year)		ORUNGEN	Roda	tt.	,							at second day
	DEC 16199	jun	" No strongest.	- WOOD	<u> </u>								

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Memtal Hygiene prior to bunal, cremation, or removal. IMPORTANT; if item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once,

	1 - STATE REGISTRAR	STATE OF MARYLAN	ID / DEPAR	TMENT OF H	EALTH AND N	MENTAL HYGIEN REG. NO.	E				
T.	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DA		3. TIME OF DEATH			
	HELEN FLORENCE FUK	Α					12 1994	10:33 Рм			
	220-05-5025	□ M 2 🖎 F 75	rs. lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JAN 22	8, BIRT	HPLACE (State or Foreign RYLAND			
OR	9a. FACILITY NAME (# not institution, give street NORTH ARUNDEL HOSP		TION		BURNIE	ATH	9c. COUNTY OF C				
2	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY		100 CITO	, TOWN OR LOCAT	TON						
L DIR		ARUNDEL	100. 011	PASADE	:NA			10d, INSIDE CITY LIMITS? 1 YES 2 NO			
VERA	1513 PUFFIN COURT			101	21122		10g. CITIZEN OF	WNAT COUNTRY?			
BY FUNERAL DIRECTOR	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	P. WAS DECEDENT EVER IN U. FORCES? 1 YES :	2 🕅 NO	If yes, sp	ENDENT OF HISPAN polity Cubart, Maxicar 2 NO Specify	IC ORIGIN? (Specify Yes n, Puarto Rican, etc.)	or No— 14, RAC Blac Spec	E — American Indian, k, Whita, etc.			
TED	15. DECEDENT'S EDUCATI (Specify only highest grade com	ON 18	(Give kind of w	USUAL OCCUPATION TO THE MONTH OF THE MONTH O	ON st of working	16b. KIND OF BUS	INESS/INDUSTRY				
COMPLETED		College (1-4 or 5+)	Hie. Do NOT us	BOARD OP		W.R.GRA	CE DAVID	SON CHEMICAL			
SON	17. FATHER'S NAME (First, Middle, Last)					WE (First, Middle, Maiden					
BE (ROBERT COLLINS				MARY	WHEEL					
9	190. INFORMANT'S NAME (Type/Print) JOSEPH F. FUKA, JR.					CADENA MAD					
	2Qe. METHOO OF DISPOSITION	20h PI		FDISPOSITION (Na		SADENA, MD	21122 CATION — City or To	num State			
	1 N Buriel 2 Cremetion 3 Removal 4 Donation 5 Other (Specify)				EMETERY		EN BURNI	1,500,000			
	21. SIGNATURE OF FUNERAL SERVICE LICENS			22. NAME AN	D ADDRESS OF FAC	HLITY		C, 110			
	- Hild Ste	811				ERAL HOME,		D 21122			
	23. PART I. Enter the diseases, or considerations that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate Interval Between										
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	hidd	et plen	lh her	my Why	varidal	Whenl	Onset and Death			
_	a	DUE TO (OR AS A CO	ONSEQUENCE OF):	1		1				
TION	Sequentielly list conditions, if any, leeding to immediate	DUE TO (OR AS A CO	ONSEQUENCE OF):							
CERTIFICATION	cause, Enter UNDERLYING CAUSE (Disease or injury thet initiated events	DUE TO (OR AS A CO	ONSEQUENCE OF):							
CERI	resulting in deeth) LAST										
Ä	PART II. Other significant conditions co	ontributing to deeth but	not resulting in	n the underlying	causa given in I	Part I. 24s. WAS AN PERFOR		. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO			
MEDIC	- Unymu	1 wen	evere con	Mu Cr	uning	1 TYES 2	NO	OF DEATH?			
Σ	DID TOBACCO USE CONTRIB	LITE TO CAUSE OF	CATH VE	S CL NO E	LINICEPTAIN			1 TYES 2 NO			
IAN	25. WAS CASE REFERRED TO MEDICAL			H (Check only one)	UNCERTAIN	1 1 1					
Sic		OSPITAL: Inpatient 2 ER/Outpatia	int 3 🗆 DOA	OTHER: 4 Nursing Hom	5 Residence	5 ☐ Other (Specify)					
PHYSICIAN:	27. MANNER OF DEATH 1 Netural 5 Pending	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	JRY WO	RK?	28d. DESCRIBE HOW IN	JURY OCCURED				
BY	2 Accident Investigation	28a. PLACE OF INJURY	At home form of	M 1 7	_	204 I CONTION (Communication)		2			
TED	3 Suicide 8 Could not be detarmined	building, atc. (Specify)	At Holling, Herrit, as	rest, factory, drifts		281, LOCATION (Street a City or Town, State)	nd Number or Hural I	Noute Number,			
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN One) 2 MEDICAL EXAMINER: O							a) and market as stated			
- 11	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED Month, Day, Yearly										
TO BE	myhand				0217	03	▶ /V/	Month Day, Yearl			
_	30. NAME AND ADDRESS OF PERSON WHO CO	APAHY MA	(ITEM 27) (Type,	Print) 51	ASAN	MALLUO	OD RI	2/122			
MICHAEL PGAKAHY MD PASADENA MO 211.											

* Items1819b,g=718,12=16=94,perf.h.,dr
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -**CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Harry Clay Fox YEAR 1805 farry 4 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH
(Month, Day, Year)
April 5, 6. BIRTHPLACE (State or Foreign 216-40-2221 DAYS April 51 HOURS 1 XM 2 F YRS. 1943 Maryland transit permit, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH Northwest Hospital Center DIRECTO Randallstown Baltimore RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore Baltimore 1 YES 2 X NO 10a. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 2907 Ridge Road 21244 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No--It yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. ables FORCES? 1 YES 2 1 Never Merried 2 Married BY 1 YES 2 NO Specify: 3 Widowed 4 Divorced R White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest Elementary/Secondary (0-12) College (1-4 or 5+) 2 Years BALTIMORE, MARYLAND National Insurance Serv. Ind Insurance Broker detache Once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) ž. hours after death. Page 6 may be retained by funeral director, page 5 should be Ħ Harry Clay Fox, Sr. BE Viola Anderson notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 21244 Mrs. Desirie Fox 2907 Ridge Road Baltimore 21207 MD pe 20a. METHOD OF DISPOSITION
1 X Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE must 4 Donation 5 Other (Specify) Resurrection Acres 12/17 Woodlawn, Maryland medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. alren 8728 Liberty Road Randallstown, in and completely filled in by the to burial, cremation, or removal. 23. PART I. Enter the disesses, or complicatione that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock, or heart fellure. Liet pnly ons cause on each line. Intervsi Between **IMMEDIATE CAUSE (Final Onset and Death** the disesse or condition resulting in desth) DUE TO (OR AS A CONSEQUENCE OF): 24 brs massine executed within event, BOX 68760. traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING the attending physician a Mental Hygiene prior to DR ATTENDING PHYSICIAN: The law requires that the death certificate be CAUSE (Disesse or injury or other DUE TO (OR AS A CONSEQUENCE OF) P.0. that initieted events resulting in deeth) LAST injury, RECORDS. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS signed by ti PERFORMED? AVAILABLE PRIOR TO shows any COMPLETION OF CAUSE 1 - YES 2 - NO OF DEATH? 1 YES 2 NO has been s Dept. of H PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 **DIVISION OF VITAL** 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) certificate har the State D HOSPITAL: 1 TES 2 NO tlent 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Realdence 6 Other (Specify) the of 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED marked, this c 1 Natural
2 Accident 5 Pending 1 YES 2 NO BY death Investigation After 3 Suicide 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) TO THE HOSPITAL DR ATTENDIN TO THE FUNERAL DIRECTOR: Af be filed within 72 hours after de IMPORTANT: If Item 28 is i after de 28 is r 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) S Could not be datermined COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month Day Year) 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 101 31. DATE FILED (Month, Day, Year) 1994 32. DEGISTRANS SIGNATURE

FOR

QHMH-16 Flav 1/89

or attending physician. w use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

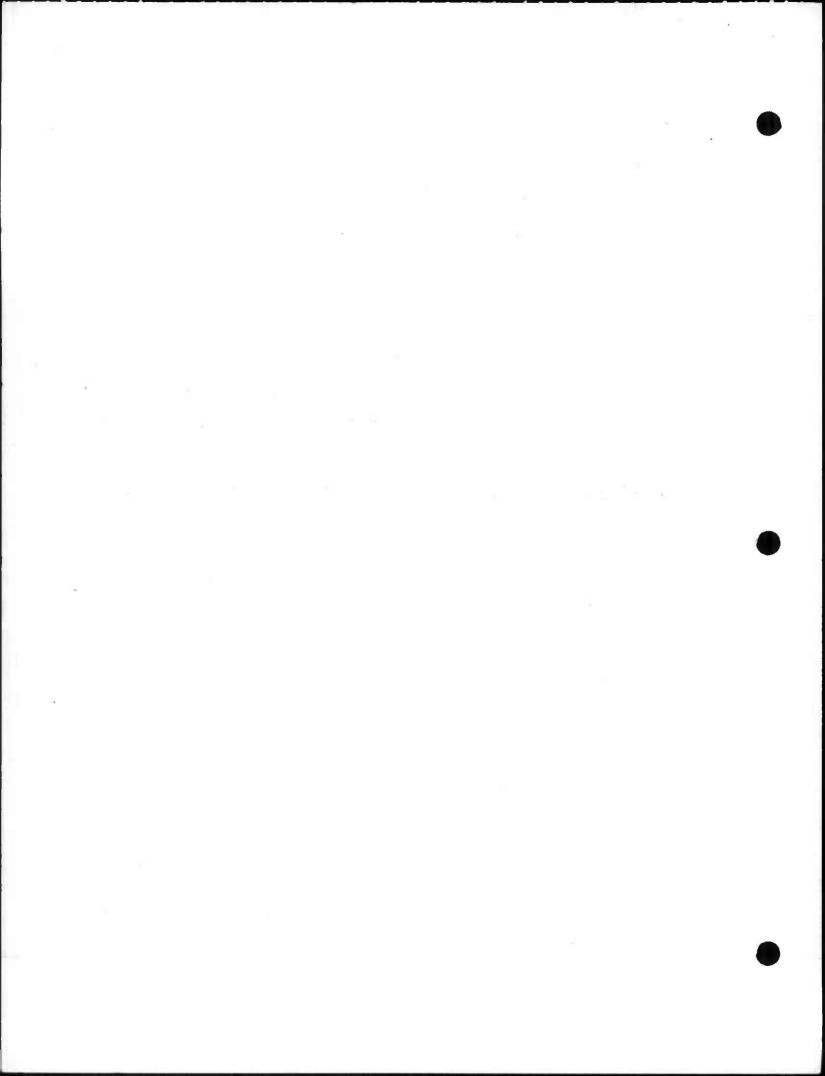
TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

I I I I I I I I I I I I I I I I I I I	TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
he funeral director, page 5 should be detached for al.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
r death. Page 6 may be retained by the hospital of	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital of

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR	STATE OF MARYLAI	ND / DEPARTM CERTIFIC			MENTAL HYGIEN				
1. DECEDENT'S NAME (First, Middle, Last)				DEMITT	2. DATE OF DEATH		3. 1	IME OF DEATH	d d
ALMA	M	GRANGER			12/ 13		94	2:30	PM
			UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		-	E (State or Fore	
020-01-0101	□ M 2 1 7	7 YRS. MO	NTHS DAYS	HOURS MIN.	6-15-191	7		Jerse	у
9e. FACILITY NAME (If not institution, give stree	t end number)	96	b. CITY, TOWN C	R LOCATION OF D	EATH	9c. COUNT	Y OF DEATH		-
MEMORIAL HOSPITA	AL & MED. (CTR. C	CUMBER	RLAND,	MD	ALLE	GHEN	Y	
10a. STATE 10b. COUNTY		10c. CITY, TO	OWN OR LOCAT	ION		10d	INSIDE CITY		
Maryland Alleg	any Co	Cum	berla				YES 2 N	WO	
	101. ZIP CODE 2.1.5.0.1				N OF WHAT COUNTRY?				
807 Maryland	Venue 2150 MAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISP				USA				
1 Never Merried 2 Merried	FORCES? 1 YES	2 NO	If yes, sp	ecify Cuben, Mexico	en, Puerto Rican, etc.)	or No 1	Black, Wh		•
3 Wildowed 4 Divorced	IF TES, GIVE WAR OR DATE	es No	1 U YES	2 NO Specif	у:		Specify:	White	7
15. DECEDENT'S EDUCAT (Specify only highest grade cor	TON 1	8. DECEDENT'S USL	UAL OCCUPATION	ON .	16b. KIND OF BUS	SINESS/INDUS	STRY		
	College (1-4 or 5 +)	(Give kind of work life. Do NOT use re	done during mo atired.)	st of working	Navy Y	ards	(WWI	I)	
12		Homema	ker					- /	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden	Surname)			
Dederick Fic	ken				ie Gruber				
19e. INFORMANT'S NAME (Type/Print)		19b. MAILINO AD	DRESS (Street e	nd Number or Aural	Route Number, City or Tow	n, State, Zip C	ode)		
Mrs Susan Grang	er	807Mar	yland.	Ave, Cun	berland,	MD 21	501		
20e. METHOD OF DISPOSITION 1	I from State cemete	ery, crematory or other		me of	DATE 20c. LO	CATION — CH	y or Town, \$	State	
21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE Ronald Wa	ade.Dir	22. NAME AN	ID ADDRESS OF FA	CILITY State	Anat	O m V	Roard	
Januar 1	Made	,			oreSt,Bal				
23. PART I. Enter the diseases, or con	pilcetione that ceused the	he deeth. Dp npt	enter the mo	de of dying, suc	h ss cerdiec or respi	ratory srres	it,	Approximat	
shock, or heart fellure. Lie iNMEDIATE CAUSE (Finei	н А			Λ			İ	Onset and	
disease or condition resulting in death)	Adenoca	rainore	BEQUENCE OF): (ulan, with				~	1. 00	
Tobaling in Country	DUE TO (OR AS A C	ONSEQUENCE OF):		1	1 1			6	17
Sequentially liet conditions, b.									/
if sny, leeding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO	ONSEQUENCE OF):							
CAUSE (Diseese or Injury C	DUE TO (OR AS A C	ONSEQUENCE OF	-						
thet initiated events resulting in deeth) LAST	00E 10 (0h A3 A C	ONSEGUENCE OF):					i		
d						_			
PART ii. Other significant conditions of	ontributing to death but	not resulting in the	he underlying	ceuse given In	Pert I. 24s. WAS AN PERFOR	AUTOPSY		E AUTOPSY FIN	
Chows Obst	with 1	-un D	iscar		1 TYES 2		COM	LABLE PRIOR TO	
)					100	YES 2 NO	5
DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTAI	N D				
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28.	. PLACE OF DEATH (C							
1 YES 2 NO	☐ Inpetient 2 ☐ ER/Outpetie		THER: Nursing Hom.	e 5 ☐ Reeldence	6 Other (Specify)				
27. MANNER OF DEATH	28e, DATE OF INJURY (Month, Day, Year)	28b. TIME OF		URY AT RK?	28d. DESCRIBE HOW II	NJURY OCCU	RED		
1 Netural 5 Pending 2 Accident Investigation				ES 2 NO					
3 Suicide 8 Could not be	28e. PLACE OF INJURY — building, etc. (Specify)	At home, farm, stree	et, factory, office		28f. LOCATION (Street e City or Town, State)	and Number or	Rural Route	Number,	
				<u></u>					
29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner es stated.									
2 MEDICAL EXAMINER: Of the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)									
D 14865 12-13-94									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
			HOSP	ITAL ME	D. BLDG.	, CUM	IBERL	AND,	MD
31. DATE FILED (Month, Day, Year) DEC 16 1994	Jahra d'Austrean	Revolute							



21222

Approximete Interval Between **Onset and Death**

Item22 12-16-94 FilmG718 W.H.Per F/H Item3 12-23-94 FilmG718 W.H.Per Doctor

hours after death. Page 6 may be retained by the hospital or attending physician. It is a should be detached for use as the burial-transit permit. Pages 1, 2, 3 should een signed by the attending physician and completely filled in by the funeral director, page 5 should be detached of Health and Mental Hygiene prior to burial, cremation, or removal. item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within THE FUNERAL DIRECTOR: After this certificate has been filed within 72 hours after death with the State Dept. of 10 28 is marked, TO THE FUNERAL OIRECTO
be filed within 72 hours at
IMPORTANT: If Item 21

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

DIRECTOR

FUNERAL

В

COMPLETED

BE

0

CERTIFICATION

MEDICAL

PHYSICIAN:

В

COMPLETED

BE

2

2

27. MANNER OF OEATH

1 Natural

2 🗋 Accident

3 Suicide

4 Homicide

31. DATE FILED (Month, Day,

DEC

FOR STATE OF MARYL STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)) / DEPAI CERTIF					MEN	TAL HYGIE REG. N			
1. DECEDENT'S NAME (First	, Middle, Last)	Elsie	E.	Gr	ay				MO	ATE OF DEATH WITH CECEMBE	r 13,	1994	3. TIME OF DEATH
4. SOCIAL SECURITY NUM	DER	5. SEX	6. AGE (In yrs	. last birthday)		R 1 YEAR	IF UNDE		7. DA	7. DATE OF BIRTH (Month, Day, Year)			IPLACE (State or Foreig
217-34-351		1 □ M 2X F	81	YRS.	MONTHS	DAYS	HOURS	MIN.	Ö'	9/21/1	913	Maryland	
9e. FACILITY NAME (If not in	stitution, give s	freet and number)		9b. CITY, TOWN OR LOCATION OF DEATH					9c. COL	9c. COUNTY OF DEATH			
Johns Hopk	ins Ba	yview Me	dical	Ctr.	Baltimore City								
10e. STATE	10b. COUNTY	1		10c. CI1	10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY		
Maryland								Dun	ida]	k			LIMITS?
10. STREET AND NUMBER						10	. ZIP COD	E			10g. CI1	IZEN OF	WHAT COUNTRY?
7013 Dunmanway Apt. A								212	222		τ	nite	d States
11. MARITAL STATUS 1 Never Merried 2 Merried \$\times \text{Wildowed} 4 \text{ Divorced} \text{ Divorced} 12. Was DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR D.				ARMED NO	- 1 - 2	If yee, sp	ENDENT (ecity Cube 2 10 NO	ın, Mexice	n, Puer	GIN? (Specify) to Ricen, etc.)	fes or No—	14, RACI Blac Spec	E — American Indian, k, White, etc.
15. DECEOENT'S EDUCATION (Specify only highest grade completed)				DECEDENT'S	USUAL O	CCUPATIO	ON set of worki	no.		16b. KIND OF B	USINESS/IN	DUSTRY	
Elementary/Secondary (College (1-4 or 5	+)	life. Do NOT u	se retired.)	and the	at or troito		Own Hame				
7 Years				Hous	ewif	e							
17. FATHER'S NAME (First, M	iddle, Last)			18. MOTHER'S NAME (First, Middle, Melden Surname)									
John G. M	iller			Mary M. Rosenthal									
19e. INFORMANT'S NAME (iype/Print)	-		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Joan Shim	anek			7013	B Dun	manv	<i>a</i> y	Apt.	A	Dunda	alk, M	aryl	and 2122
20a, METHOD OF DISPOSIT 1/9 Suriel 2 Cremetic 4 Donation 5 Other	n 3 🗆 Reme	oval from State	20b. PLA cemetery Gar	CE AND DATE cramatory or c rison	of bispos	sition (Ne	me of	em.1	2/1	ATE 20c. I	Owing		wn, State
21. SIGNATURE OF PINERA	LIPERVICELIO	esset L	11			_			-		ne of	Dund	alk, Inc.
1 new	UN	ty	1					. Ave		Dunda1			
23. PART I. Enter the d shock, or h	seesea, Dr c	complications the	t obused the	deeth. Do									Approximete
23. PART I. Enter the diseasea, Dr complications that deused the dees shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSECTION				ISEOUENCE O	Cer	l	à		ele	ett			Onset and D
DUE TO (OR AS A CO)					Ober 1	h	fd	ise	is	ton			
PART II. Other algolfica	nt condition	a contributing to	death but n	ot resulting	In the ur	nderlyln	ceuse	alven In	Pert I.	24a, WAS /	AN AUTOPSY	246	WERE AUTOPSY FINDS

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 TYES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? OTHER:

HOSPITAL: EN/Outpatient 3 DOA 280. DATE OF INJUSTY

28b. TIME OF INJURY

ng Home 5 🗆 Residence 8 🗆 Other (Specify) 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCURED

1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, streel, factory, office building, etc. (Specify)

281. LOCATION (Street end Number or Rural Route Number, City or Town, State)

29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and menner es stated.

MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and menner as stated. 295 BIGNATURE AND STILE OF CENTIFIER 29c. LICENSE NUMBER

Investigation

8 Could not be

29d, DATE SIGNED (Month, Day, Year)

DDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

Studior Rand

DHMH-16 Rev 1/89

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPARTM			MENTAL HYGIE			
		1. DECEDENT'S NAME (First, Missey Last)		SALLIE (GRIFF	IN		DAY 28 7	YEAR 1235	PM
pin		4. SOCIAL SECURITY NUMBER 250-60-0374 90. FACILITY NAME (If not institution, give st.	1 □ M 2 x = 7	3 YRS. MOR	UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) JULY 27,	1921 8	BIRTHPLACE (State or Foreign Country) SOUTH CAROLI	_
, 2, 3 should	стоя		PITAL	96.		IMORE CI			BALTIMORE	
permit. Pages 1,	DIRE	10e. STATE 10b. COUNTY	LTIMORE	10c. CITY, TO	BALT	IMORE CI	TY		10d. INSIDE CITY LIMITS? 1 X YES 2 NO	o
nsit	ERAL	100. STREET AND NUMBER 1800 HOLLINS			101	. ZIP CODE			N OF WHAT COUNTRY?	
215-0020 attending physician. se as the bunal-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 💢 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	NNO ON	Il yes, sp	ENDENT OF HISPAI ecify Cuban, Mexica 2X NO Specif	NIC ORIGIN? (Specify Y an, Puerto Rican, atc.) y:	es of No — 14	t. RACE — American Indian, Black, White, etc. Specify: BLACK	
ND 21215 hospital or attend lached for use as ce.	LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) 10th GRADE	CATION completed) College (1-4 or 5+)	Give kind of work life. Do NOT use ref	done during mo ired.)	st of working		USINESS/INDUS		
ALTIMORE, MARYLA death. Page 5 may be retained by the e funeral director, page 5 should be de ii. examiner must be notified at on	TO BE COMPL	17. FATHER'S NAME (First, Middle, Last) VICTOR	GREGORY	DOMEST	IC WOR		UNKNO		TPD	_
		190. INFORMANT'S NAME (Type/Print) DORA HUNTH				nd Number or Rural	Route Number, City or To	own, State, Zip Co		
		20e. METHOD OF DISPOSITION XXX Burlel 2	cemeter	ACE AND DATE OF DI ry, crematory or other p ZION CE	SPOSITION (Ne	ome of	DATE 20c. L	OCATION — CIT	y or Town, State	_
		21. SIGNATURE OF FUNERAL SERVICE LICE	WNW		JOSEP		WN JR. FU	NERAL H		223
within 24 hours pletely filled in termation, or referred		23. PART I. Enter the disasses, or control of the c	omplications that caused the list only one cause on each	Ilna.				piretory arrea	Approximate interval Betwo	меап
OX 68 be execute cian and co ior to buna	RTIFICATION	Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury	E TO (OR AS A CO		/					
P.O. h certific anding p Hygien or othe	ш	that initiated events resulting in death) LAST	DUE TO (OR AS A CO	NSEQUENCE OF):						
AL RECORDS, F e law requires that the death has been signed by the atte Dept. of Health and Mental 123 shows any injury, or	IN: MEDICAL C	PART II. Other significant conditions Right Hyperter DID TOBACCO USE CONTR	Veningion	Anti	i Res	engilal	PERFO 1 YES	24b. WERE AUTOPSY FIND MAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 PNO		
TA He He	HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	26. I		HER:	e 5 🗆 Raeldence	6 Other (Specify)			
ON OF VOING PHYSICIA After this certification with the smarked, or	ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	M 1 🗆 1	RK? /ES 2 NO	26d. DESCRIBE HOW	INJURY OCCUP	RED	
TTENOI TTENOI TTOR: A after da	ETED	3 Suicide 6 Could not be 4 Homicide determined	28s. PLACE OF INJURY — J building, etc. (Specify)	At home, term, street	, tectory, affici		28I. LOCATION (Stree City or Town, State	t end Number or s)	Rural Route Number,	
로 경험 로	COMPL		EIAN: To the best of my knowledges: On the basis of examination en							ıd.
TO THE HOSPI TO THE FUNER be filed within	TO BE (29b. SIGNATURE AND TITLE OF CERTIFIER	Veurosa	ngan	29c. LICENSE NUMBER 29d. DATE SIGNED (A					
(0)	-	30. Name and address of Person who P. Volle Ly 22	- 5 Creens	(ITEM 27) pype, Print	Balt	ranore	MD	2 (201	7	
19		31. DATE FILED (Month, Day, Year) DEC16 1994	32 REGISTRAR'S SIGNATUR	RE COLL						

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The has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be by the attending physician prior to bunal, cremation, or removal.

The shows any Injury, or other traumatic event, the medical examiner must be notified at once. In the law requires that the death certificate be executed with TO THE HOSPITAL OR ATTENDING PHYSIC TO THE FUNERAL DIRECTOR AREA MIS CE be filed within 72 hours after own with IMPORTANT: If Item 28 is married

5

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

ABOO, SUTANNE 201 EAST UNIV. PKWY

31. DATE FILED (Month, Pay, Year)

DEC10 1994

32. REGISTRAR'S SIGNATURE

											ر	p.), (1167		
	FOR	OTATE OF A	EADW AND	, DED45											
	1 - STATE REGISTRAR	SIAIE UF N	TARYLAND	ERTIF	ICAT	I UF I	DEAT	AND I		GIENI G. NO.	E				
	1. DECEDENT'S NAME (First, Middle, Last)				IOAI	<u> </u>	DEA		2. DATE OF DE				3. TIME OF DEAT	'м	
	F.FFIE G	UIN							DECEMBE	DA		YEAR 194	12.51	Δ.,	
		SEX							7. DATE OF BIF		7 '	· , ,	PLACE (State or Fo	onian	
	239-14-4769	_ M 2 Q F	M 2 F 75 YRS. MONTHS DAYS HOURS MIN.					MIN.	(Month, Day, Year) Country)				r)		
	9e. FACILITY NAME (If not institution, give street	and number)			9b. CIT	TOWN I	OR LOCATH			1 19		NOT	th Carol	.1na	
Œ								St. 000	MIT OF DE	-810					
18	RESIDENCE OF DECEDENT														
DIRECTOR	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN	OR LOCA	TION						10d. INSIDE CITY		
	Maryland			В	alt	imor	e						XXYES 2	NO	
AL	10e. STREET AND NUMBER					10	. ZIP CODE				10g. CIT	ZEN OF W	HAT COUNTRY?		
FUNERAL	2042 East Presto	n Stre	eet				212	13				USA			
ا جُ			T EVER IN U.S. AI		13				IIC ORIGIN? (Spe n, Puerto Ricen,		or No-	14. RACE	- American India, White, atc.	en,	
84	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE W	AR OR DATES				2 NO			itc.)		Specif			
											!		Black		
	15. DECEDENT'S EDUCATI (Specify only highest grade con	npleted)	(0	ECEDENT'S Sive kind of a. Do NOT u	work done	during mo	ON ast of workin	g	16b. KIND	OF BUS	INESS/INE	DUSTRY			
ا يّا ا		College (1-4 or 5 +)				~			-					
COMPLETED	10th Grade 17. FATHER'S NAME (First, Middle, Last)			omin	0 5	uqar					acke	er			
	The second secon								ME (First, Middle,		Surname)				
H	Giles Marshall 196. INFORMANT'S NAME (Type/Print)		46	- MAH INC	ADDDE	00 (0)			rta Ma						
일		1											01010		
	Carlean Campbel		2042 East Preston Street Baltimore,									3			
	1 Donation 8 Other (Specify)	from State	cemetery, cn	emetory or o	ther plece	9)		_	1			cel, Maryland			
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE	Mary1	.ano	Nat1	ONA J.	Pari	S OF FA					Homes, I	na	
	May I W	-000			25	501 (wvnn	s Fa	1.1.s Par	lcwa	rune. V	Lal. I	nomes, 1	inc	
\square	Clase of M	den	2		JBa	altin	more,	Mar	'yland	212	16				
	23. PART I. Enter the diseases, or com shock, or heart fellure. List	iplicetions the t only one ceu	ceused the de se on each line	eeth. Do i e.	not ente	r the mo	de of dyl	ng, sucl	h aa cerdlec o	respli	ratory an	rent,	Approxima		
	IMMEDIATE CAUSE (Finel												Onset and		
	disease or condition		ric Sh										SEVARA	4 hours	
	ł.		(OR AS A CONSE		,	_							sevual		
NO N	Sequentially list conditions,	FND	STAGE OR AS A CONSE	. KEI	MAL	FA	LUT	5					years		
ERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING		ESTIVE			C							Sevud		
윤	CAUSE (Disease or Injury C	DUE TO	OR AS A CONSE	OUFNCE O	CT D:	TAL	LUKE	-					years		
Ē	thet initiated events resulting in death) LAST	PER	FORAT	Tes	Suc	12 TI	1						SIVULA		
핑	d	1 671	FURAT		10		(4)						DAYS		
A	PART II. Other significent conditions c	ontributing to	deeth but not	resulting	In the u	ınderiyin	g ceuae g	lven in		MAS AN	AUTOPSY MED?		WERE AUTOPSY FIL		
EDICAL									1	YES 2	1		COMPLETION OF CO		
M												- 1	1 YES 2 N	10	
ż	DID TOBACCO USE CONTRIB	UTE TO CA	USE OF DEA	ATH YE	S 🗆	NO [UNC	ERTAIN	1 12						
¥	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLA	CE OF DEA											
100		OSPITAL:	ER/Outpatient 3	DOA	OTHE		e 5 □ Re	sidence	8 Other (Spec	lfy)					
27. MANNER OF DEATH 1 V Netural 5 Pending (Month, Day, Year) 28e. DATE OF INJURY (Month, Day, Year) 28e. TIME OF INJURY AT WORK? M 1 YES 2 NO 28e. PLACE OF INJURY — At home farm street factory of the control of								JURY OC	CURED						
								oute Number,							
Solution of be determined building, etc. (Specify) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as attend.															
PLE	290. CERTIFIER 1 CERTIFYING PHYSICIAN	N: To the best of	my knowledge, de	eath occurr	ed at the	time, date	end piece.	and due	to the couse(e) o	nd men	ner se stel	led.			
NO I	one) 2 MEDICAL EXAMINER: 0												end manner ee st	ated.	
	20h SIONATINE AND TITLE OF OCCUPIED	-					29c. LICE						(Month, Day, Year)		
H	Sugarne Ch	udo,	MD									2191	94		
0 1															

21218

3. TIME OF DEATH

Onset and Death loday

12:40 P 8. BIRTHPLACE (State or Foreign Virginia

REG. NO.

30,1994 YEAR

2. DATE OF DEATH

NOV.

		4. SOURE SECONITY NUMBER	5. SEX	6. AGE (In yrs. la	,,	MONTHS	DAYS	HOURS	MITTO.	7. DATE OF BI (Month, Day,	Year)		Country)	ACE (State or Foreign
9		213-26-2105	1 🗆 M 2 😾 F	8	4 YRS.					June 26	5, 19			inia
3 should	~	90. FACILITY NAME (If not institution						OR LOCATIO		ATH		9c. COUNT	Y OF DEAT	н
. 2.	DIRECTOR	Maryland Gener				В	alti	more						
Sage	H H	10m. STATE 10b. C	OUNTY		10c, CIT	Y, TOWN	OR LOCA	TION					100	d. INSIDE CITY LIMITS?
·=;	1 11	Dul Cilloic								t [YES 2 NO			
L bed	₹	10e. STREET AND NUMBER					10	f. ZIP CODE	E			t0g. CITIZE	N OF WHA	T COUNTRY?
an. Transit	FUNERAL	4050 Elmora						212					SA	
020 physician. burial-transit permit. Pages 1, 2,		1 Never Merried 2 Merried	12. WAS DECEDEN FORCES? 1	YES 2 V	NO NO		It yes, sp	ecity Cuba	n, Mexican	IC ORIGIN? (Sp. , Puerto Rican,	atc.)	or No 1-	4. RACE — Black, W	Americen Indian, hite, etc.
9 5 5	ВУ	3 Widowed 4 Divorced	IF YES, GIVE Y	MAR OR DATES 21			t YES	2 🗌 NO	Specify				Specify:	Black
AND 21215-0020 the hospital or attending physic detached for use as the bunial once.	COMPLETED	15. DECEDENT (Specify only highes	S EDUCATION t grade completed)	16a. Di	CEDENT'S	USUAL O	CCUPATIO	ON ost of workin	na	16b. KIND	OF BUSI	NESS/INDU	STRY	DIGUR
		Elementary/Secondary (0-12)	College (1-4 or 5	+)	. Do NOT us	se retired.)								
AND 2 the hospital detached for	ME	8th Grade 17. FATHER'S NAME (First, Middle, LA			Hous	ekee	epi	Y				vate		
YLAND by the hospit be detached at once.	- 1	Walton Ormil	181)					101		ME (First, Middle,		umeme)		
MARY retained to 5 should	BE	190. INFORMANT'S NAME (Type/Prin	1)	19	b. MAILING	ADDRESS	S (Street)			Johns loute Number, Cit		State 7/n C	'orde)	
My 5 sh	2	Judith Hedge	Peth					a Av					Mary	21213
BALTIMORE, er death. Page 6 may be the funeral director, page val.		20a. METHOD OF DISPOSITION †☐ Buriel 2 ☐ Cremetion 3	12.72.74.00	20b. PLACE	AND DATE	OF DISPOS			CIIac				ty or Town,	
MOR ge 6 ma irector, p		Donation 5 Other (Specify		emetery, cre Arbut	us M	emor:	ial	Park		Dec ₆	Ba1t	imore	e. Ma	ryland
death. Page tuneral direct.		21. SIGNATURE OF FUNERAL SERV	ICE LICENSEE			22.	NAME A	ND ADDRES	SS OF FAC	Nutt	er F	uner	al. Ho	mes, Inc
0 = 0		perm	tarken			b:	201	GWYN	ns ra Mai	alls Pa ryland	irkwa 212	1y 216		
B. nours after of in by the or removal		23. PART I. Enter the disease	s, or complications the	et caused the d	eath. Do r	ot anter	the mo	de of dyl	ng, such	as cardisc o	or reapire	atory street	Bt,	Approximate
To be		IMMEDIATE CAUSE (Finei	ndle. Liet billy blie cet			_			,					Onset and Death
t, tt		disease or condition resulting in death)	e		VEY		re	si/	MIN	2				loday
De of le			DUE TO	(OR AS A CONSE	OUENCE O	F):	1	- 1	-	1. 1.		•	4.3	lada
668 and attic	ON	Sequentially list conditions,	b. DUE TO	OR AS A CONSE	CUTO (elli	wa	~ '	005	Nuchi	e /	aun	uu	loday
BOX ate be en hysician a prior to	CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING		(-)		,.		•			U			
. 6 4 5	Ĕ	CAUSE (Disease or Injury thet initiated evants	DUE TO	(OR AS A CONSE	OUENCE OF	F):								
eath certi attending mtal Hygie	E	resulting in death) LAST	d											
	- 11	PART II. Other significant con	ditione contributing to	deeth but not	resulting	In the un	derivin	a ceuse a	ivan in i	Part i. 24s.	WAS AN A	LITOPSY	T 24h WE	RE AUTOPSY FINDINGS
- # - # -	MEDICAL										PERFORM	ED?	CO	MILABLE PRIOR TO MPLETION OF CAUSE
Sign Sign Heal										_ '⊔	YES 2	Kuo	1	DEATH? YES 2 NO
L RE law req as been bept. of 23 sh	ä	DID TOBACCO U	SE CONTRIBUT	E TO CAU	SE OF	DEA.	TH Y	YES [NO	M			'] 120 2 [110
TAL The last tate Des	ICIAN:	25. WAS CASE REFERRED TO MEDI- EXAMINER?	HQSPITAL:					LACE OF DI	EATH (Che	ck only one)				
F VI SICIAN: certifica h the Str	YSI	1 WES 2 NO	1)Sinpatient 2		□ DOA	4 Nun	R: sing Hom	ne 5 🗆 Re	sidenca (8 Other (Spe	ctfy)			
/ISION OF VI ATTENDING PHYSICIAN. COOR: After this certific s after death with the S 28 is marked, or i	PHYS	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF (Month, D	Pay, Year)	28b. TIM	E DF URY		PK?		28d. DEŞCRIBI	E HOW INJ	JURY OCCU	RED	
ON OF DING PHYS After this of death with	ğ	2 Accident Investig	ation	NE IN HIDY As be		M I		YES 2						
VISIC ATTEND ATTEND CCTOR: /		3 Suicide 6 Could r	oulding,	OF INJURY — At he etc. (Specify)	ине, тегит, г	mreet, rect	огу, опіс			26t. LOCATION City or Tow	(Street en n, Stete)	d Number or	Rural Route	Number,
DIVISION OR ATTENDING OHECTOR: After News after death	9	29a. CERTIFIER	PUNCTOLANI TO ALL TO AL									ue Silie		
	A P		PHYSICIAN: To the best of AMINER: On the basis of e											d manner no stated
1212	3	298. BIGNATURE AND FITLE OF CE				, ,, o	, c							
# ZZ	림	(m lasar	thaken	mar	1	11)		20 /	L5 (29d. DATE S	SIGNED (Mo	onth, Day, Year)
P 2 2 ₹	2	30. NAME AND ADDRESS OF PERSO	N WHO COMPLETED CAU	SE DF DEATH (ITE	M 27) (Type,	Print)						, 11	140	71919
)			DR.M.	vasant	hala	uma	w	MD	82	I, N.E	2U7A	WST	, Suiti	407. MD
		31. DATE FILED (Month, Day, Year)	Sanegistra	M'S AGNATURE		_	I				 _			B1-0
	1	DELL U MM4	There we would											

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

Gross

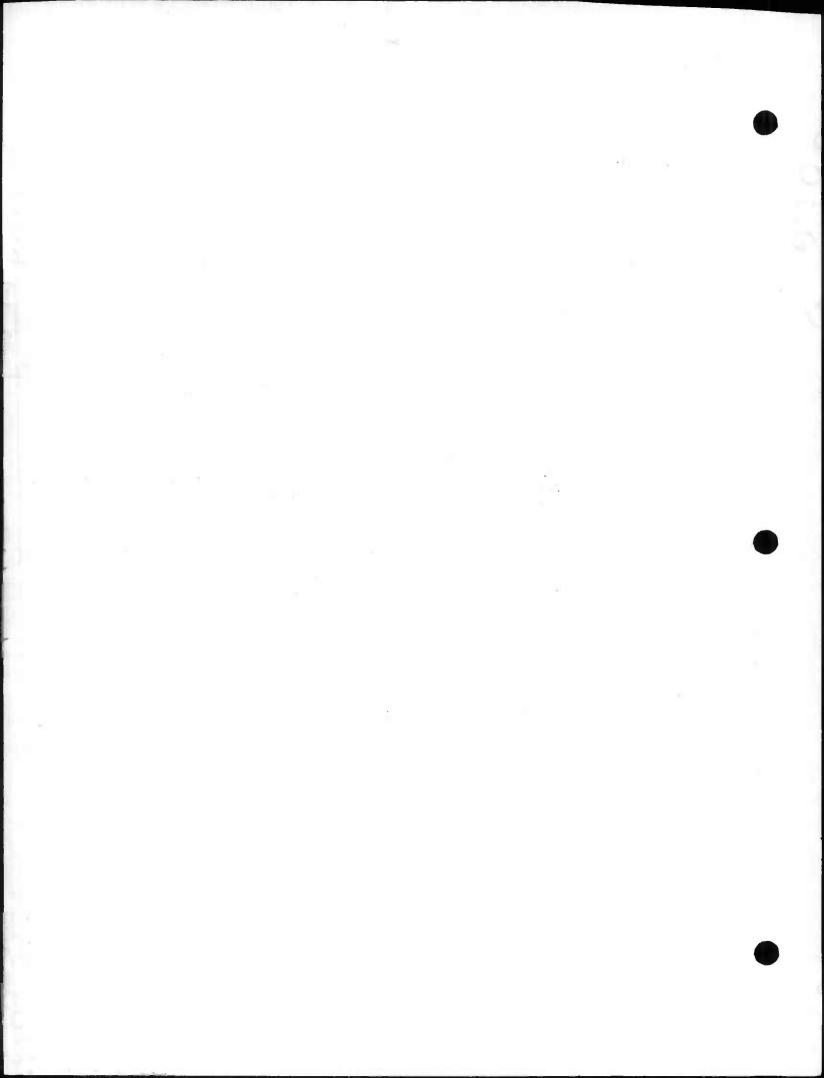
1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Azalee

DEC16 1994

DHMH-16 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

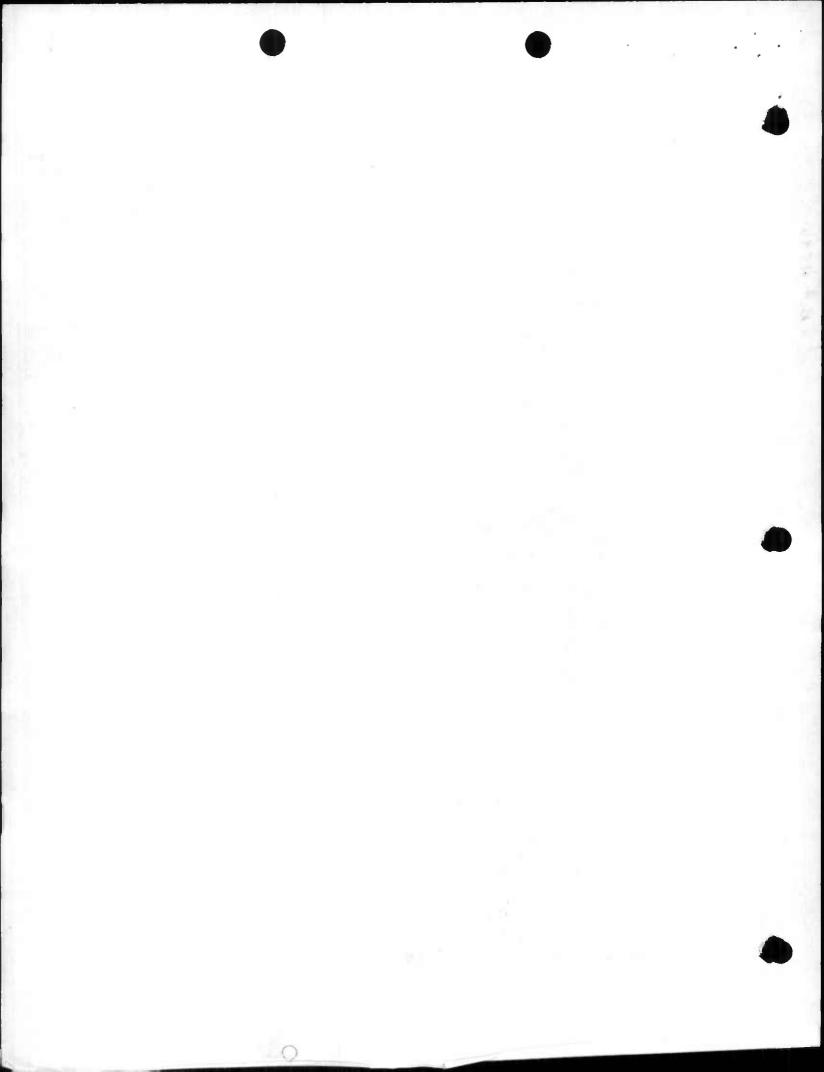
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within profits and ceath. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dopt. of Health and Merital Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO.											
	1. DECEDENT'S NAME (First, Middle, Last) Tanisha Chantelle Goldring RABY GIRL GOLDRING TWIN A 2. DATE OF DEATH MONTH DAY 94 10:15 8 M											
	4. SOCIAL SECURITY NUMBER 5. SEX 1 MONTHS DAYS HOURS MIN. 1 M 2 F 6. AGE (In yrs. last birthday) IF UNDER 14 YEAR IF UNDER 24 HRS. YRS. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN. 1 MONTHS DAYS HOURS MIN.											
TOR	90. FACILITY NAME (If not institution, give street and pumber) Prince George's Prince George's											
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS!											
Lanifol Halonte												
FUNERAL	12.19 Balboa Ave. Apt. 304, Capiton Hg/s, Ud 20743 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. 14. RACE - American Indian.											
B	1 Never Merried 2 Married 1 Yes 2 NO 1 Y											
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY											
COM	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname)											
B	190. INFORMANT'S NAME (Type/Print) DI 100 MAILING ADDRESS (Street and Number or Paural Poute Number, City or Topun, State, Zip Code)											
2	Lashawy Mulpor 1219 Balboa Aug Apt. 304, Capital Higher, Mazort											
	20e. METHOD OF DISPOSITION t											
,	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
CERTIFICATION	shock, or heert fallure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST Approximates interval Between Onset and Death LISTICALY Failure 19 WILKS QESTATION DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
- 11	PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 24s. WAS AN AUTOPSY FINDINGS											
: MEDICAL	PERFORMED? t											
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:											
PHYSICIAN: ME	1 YES 2 NO 1 Inpettent 2 ER/Outpettent 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 288. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED											
ВУР	t Natural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO											
	3 Suictde 8 Could not be determined 28e. PLACE OF INJURY — At home, tarm, street, factory, office building, atc. (Specify) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.											
H	296. SIGNATURE AND TITLE OF CERTIFIER WITH UP 290. LICENSE NUMBER 29d. DATE SIGNED (Month, Opy, Year) 8-14-94											
2	Vivac Georges Hospi Center, Chevery, Md											
	DEC1 7 1994 32. SECISTRAR'S SIGNATURE Julia Shurles Revell											



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTII	FICATE O	F DEATH	RE	G. NO.			
	1. DECEDENT'S NAME (First, Middle, La	•	R GRA	11=0		2. DATE OF OE MONTH	DAY	VEAD	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER	, , , , , , , , , , , , , , , , , , , ,			1	12		94	6:40 AM	
CONTROL	228-64-5100	7 1 M 2 □ F	GE (In yrs. last birthday,	MONTHS DAYS		7. DATE OF BIF (Month, Day,		Country	PLACE (State or Foreign	
œ	9a. FACILITY NAME (If not institution, gir			W	OR LOCATION OF DE	ATH	9c. COU	NTY OF DE	ATH	
DIRECTOR	Good Samaritan	Hospital		Bal.ti	more					
REC	10a. STATE 10b. COU		10c. C	TY, TOWN OR LO	CATION				10d. INSIDE CITY LIMITS?	
	Maryland		B	altimore	<u> </u>				1X YES 2 NO	
FUNERAL	100. STREET AND NUMBER 1414 Northqate	Road			21218		10g. CIT	IZEN OF W	USA	
ВУ	11. MARITAL STATUS 1 X Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVE FORCES? 1 YES, GIVE WAR OF	ES 2 X NO	If yes,	ECENDENT OF HISPAN specify Cuban, Maxica ES 2 NO Specify	n, Puarto Rican,	cify Yea or No— etc.)	14. RACE Black, Specify	- American Indian, White, etc.	
E	15. OECEDENT'S E (Specify only highest gr			S USUAL OCCUPA work done during		16b. KIND	OF BUSINESS/IN	DUSTRY		
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT	use retired.)	•					
MP	17. FATHER'S NAME (First, Middle, Last)	College 5+	Tea	acher	do mornista un			ty Pu	ablic Sch	
ECC	Vester Graves,	٦r.			18. MOTHER'S NA	we (First, Middle, ly Swann				
00	19a. INFORMANT'S NAME (Type/Print)	01.	196. MAILIN	O ADDRESS (Stree	t and Number or Rural F			Code)		
10	Handy Graves								inia 24541	
	20e. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 R		20b. PLACE AND DATE	OF DISPOSITION	Name of	DATE	20c. LOCATION —	City or Tow	vn, Steta	
	4 Donation 5 Other (Specify)		Danville	Memoria	1 Gardens	Dec ₅	Danvill	e, Vi	irginia	
	21. SIGNATURE OF FUNERAL SERVICE	Palker		22. NAME 2501	Gwynns F imore, Ma	alls Pa	er Fune Irkway	ral H	Homes, Inc	
CERTIFICATION	23. PART I. Enter the diseases, o shock, or heert failur IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. RESPIRA DUE TO (OR A	ATORY AS A CONSEQUENCE	FAILU A					Approximate Intervsi Between Onset and Death	
	Sequentially list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): PNEU MON/A- DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
	PART ii, Other significent condit	ons contributing to deat	h but not resulting	in the underly	ing ceuse given in		MAS AN AUTOPSY		WERE AUTOPSY FINDINGS	
MEDICAL						1 - 1	YES 2 NO		AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
AN	DID TOBACCO USE CON 25. WAS CASE REFERRED TO MEDICAL	ITRIBUTE TO CAUSE				1 🗆				
PHYSICIAN:	EXAMINER?	HOSPITAL:		OTHER: 4 Nursing He	ome 5 🗆 Rasidenca	\$ Other (Spec	ily)			
BY PH	27. MANNER OF DEATH 1 Netural 5 Pending Investigation	28a. DATE OF INJUF (Month, Day, Yea		IJURY \	NJURY AT YORK? YES 2 NO	28d. DESCRIBE	HOW INJURY OC	CURED		
ETED	3 Suicide S Could not 0	28a, PLACE OF INJU- building, atc. (S	JRY — At home, farm, Specify)	street, factory, of	Nca	28f. LOCATION City or Town	(Street and Number n, State)	or Rural Ro	oute Number,	
COMPLE	1	YSICIAN: To the best of my kn							and menner as stated.	
TO BE C	296. BIGMATURE AND TITLE OF CONTR	· Sul -	MD.		POSO	BER 73	29d, DAT	E SIGNED ((Mgrith, Day, Year)	
	31. DATE FILED (Month, Day, Year)	MHO COMPLETED CAUSE OF	O LOC	HRA	VEN B	(VD-	BALT	1701	CE 170212	
	DEC 16 1994	John Dhudson	Rardall						30	

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

OHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an incompletely filled in by the interest director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE REGISTRAR	STATE OF MARYLA		ENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIENE REG. NO.	
	1. DECEDENT'S NAME (First, Middle, Last)	NCON			2. DATE OF DEATH MONTH DEC 12	3. TIME OF DEATH
	NATHANIEL HEI	NSON 5. SEX 6. AGE (II	n yrs, last birthday) IF L	INDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	94 6:05P M
	2/3-70-0434 90. FACILITY NAME (If not institution, give s	1 M 2 🗆 F	36 YRS. MON	THS DAYS HOURS MIN.	02-14-58	Country)
OR	BALTIMORE CIT	$rac{ ext{Y} ext{ } ext{DETENT}}{ ext{ION}}$	1	BALTIMORE C		NTY OF DEATH
DIRECTOR	10a. STATE 10b. COUNT	Y	10c. CITY, TO	WN OR LOCATION		10d, INSIDE CITY
	100, STREET AND NUMBER		B	ALTINORE		1 YES 2 NO
FUNERAL		SHEL ST	-	101. ZIP CODE 2/2/	7	U.S.A.
F	11. MARITAL STATUS 1 Never Merried 2 Merried	12. WAS DECEDENT EVER IN FORCES? 1 YES	2 NO	13. WAS DECENDENT OF HISPA It yee, specify Cuban, Mexic	NIC ORIGIN? (Specify Yee or No— an, Puerto Rican, atc.)	14. RACE — American Indian, Black, White, stc.
Э ВУ	3 Widowed 4 Divorced	IF YES, GIVE WAR OR OA	TES	1 TYES 2 NO Speci	lly:	Specify: BLACK
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondery (0-12)	College (1-4 or 5+)	(Give kind of work of life. Do NOT use reti	lone during most of working	16b. KIND OF BUSINESS/INI	DUSTRY
MPL	12grade	Conlege (14 or 5 +)	NON	IĒ.		
OS	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S N	AME (First, Middle, Malden Surname)	Liland
BE	19e. INFORMANT'S NAME (Type/Print)	4	105 MAILING ADD	RESS (Street erid Number or Rural	POUTE Number_City or Town, State, Zie	EN3ON
2	GWENdolyN ,	HENSON	1236	UOSHEL S	T BALTO. 14	4 21217
	20a. METHOD OF DISPOSITION 1 District 2 Cremetion 3 Rem 4 District 5 Other (Specify)	oval from State 20b.	PLACE AND DATE OF OR		DATE 20c. LOCATION	City or Town, State
	21. SIGNATURE OF FUNERAL/BERVICE UN		7407.0	22. NAME AND ADDRESS OF FA	E. BROWN CO	NHANTS E /4
	1 /1 CA	Durun		1206 W.	NORTH AVE	/
	23. PART I. Entar tha diseasas, or shock, or hasrt failura.	complications that caused List only one cause on ea	the deeth. Do not e ch lina.	nter the mode of dying, suc	ch es cerdiec or respiratory en	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Acquer	ED IM	nine Dot	rierch (yr	Onset and Death
	- Tooling in Seattly	DUE TO (OR AS A	CONSEQUENCE OF):) 30	707
CERTIFICATION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF):			
FICA	cause. Entar UNDERLYING CAUSE (Disesse or Injury that initisted events	cOUE TO (OR AS A	CONSEQUENCE OF):			
ERTI	resulting in death) LAST	d				
AL C	PART ii. Other algnificant condition	na contributing to death bu	it not resulting in th	e underlying cause given in	Part 1. 24a, WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
					PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTI	RIBUTE TO CAUSE OF	DEATH YES	□ NO □ UNCERTAI	N D	1 TYES 2 NO
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		6. PLACE OF DEATH (C	neck only one)		
YSI	XX YES 2 NO	1 Inpatient 2 ER/Outpa	itlent 3 DOA 4 D	HER: Nursing Home 5 - Residence		NTION CNTR
ВУ РН	1 Natural 5 Pending Investigation	26e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OC	CURED
	3 Suicide 6 Could not be 4 Homicide detarmined	26e. PLACE OF INJURY - building, etc. (Specif	At home, ferm, street.	factory, office	281. LOCATION (Street and Number City or Town, State)	or Rural Route Number,
PLE	29e. CERTIFIER 1 CERTIFYING PHYSI	ICIAN: To the best of my knowle	edga, death occurred at	the time, date end place, and dur	to the cause(e) end menner as star	led.
COMPLETED					time, date end place, and due to the	
BE	296, SIGNATURE AND TITLE OF CERTIFIER	locke	aM)	29c. LICENSE NU O . C .		E SIGNED (Month, Day, Year) EC . 13/94
10	36 HAME AND ANOMEST OF PERSON WH				ore, Marylan	d 21201
	31. DATE FILED (Month, Day, Year)	ALIA DANBERTHANS SING		- Darein	oze, naryran	<u> </u>
	DEC1 6 1994	Jakon at author ma				``

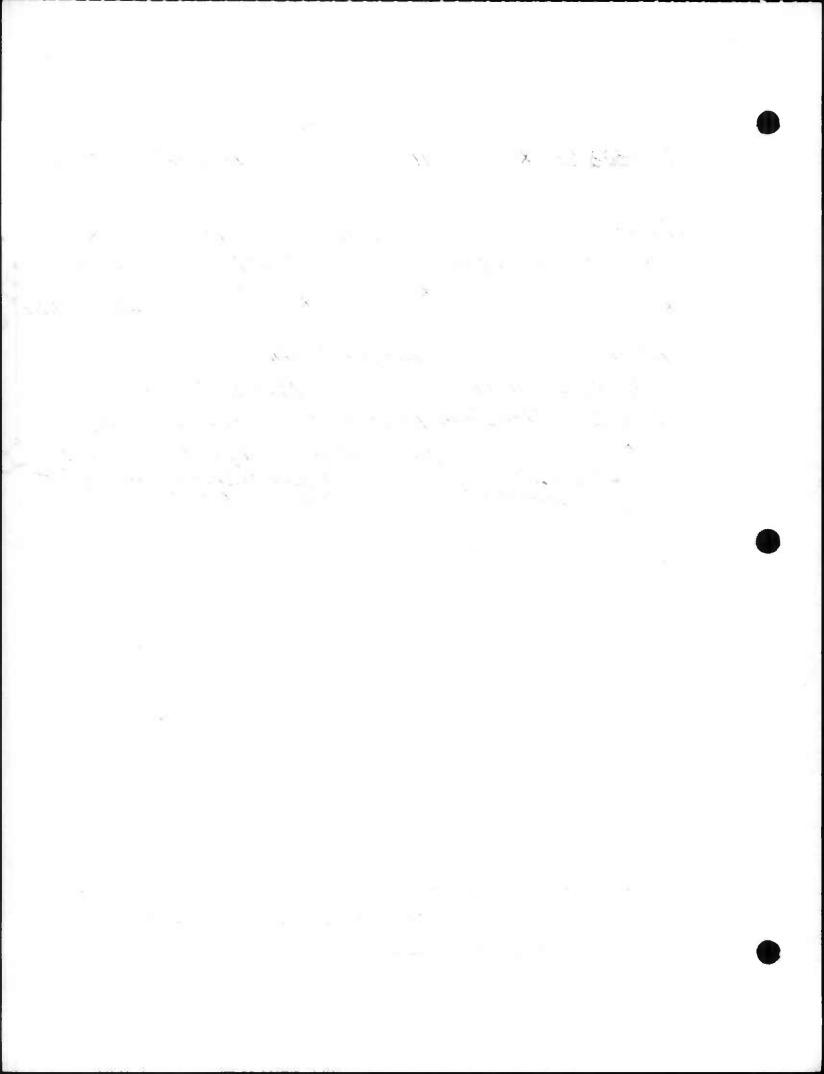


A Maria Company × N. 11. 1 -

STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OFATN YEAR CEPHUS HARRIS DEC 94 **4** N 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 5 SEX 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign Country) 1 M 2 - F DAYS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MARYLAND GENERAL HOSPITAL permit. Pages 1, 2, 3 BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 LAND 1 X YES 2 NO 816 L FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 2/2/ use as the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.)
 T YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Married BY 3 Wildowed 4 Divorced ED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest g COMPLET signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for Heath and Mental Hygiene prior to burial, cremation, or removal. ntery/Secondary (9-12) College (1-4 or 5+) 17. FATNER'S NAME (First, Middle, Last) notified at BE 19a. INFORMANT'S NAME (Type/Print) 2 pe 20a. METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Re must 4 Donetion 5 Other (Specify) 21. BIGNATURE OF FUNEBAL SERVICE LICENSE examiner 206 the medical 23. PART i. Effet the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, Approximate ahock, or heert failure. List only one cause on each line. Intervsi Between IMMEDIATE CAUSE (Final Onset and Death disease or condition ____ lles ochechi event. DIVISION OF VITAL RECORDS, P.O. BOX 68760, OUE TO (OR AS A CONSEQUENCE OF) other traumatic CERTIFICATION Sequentially list conditions, DUE TO JOB AS A CONSEQUENCE OF if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 10 shows any Injury, PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY 246. WERE AUTOPSY FINOINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO this certificate has been with the State Dept. of PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN HOSPITAL DR ATTENDING PHYSICIAN: The law i Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 X YES 2 NO 1 | Inputient 2 | XER/Outputient 3 | DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OESCRIBE NOW INJURY OCCURED is marked, Natural 2 Accident Pending 1 YES 2 NO ВУ death Investigation DIRECTOR: After 28a. PLACE OF INJURY — At home, farm, street, factory, office 3 Suicide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined COMPLETED after 28 4 Nomicide TO THE FUNERAL DIRECT
De filed within 72 hours a
IMPORTANT: If Item 2 29e. CERTIFIER 1 _ CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and menner as stated. 2 XMEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIES BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 표 O.C.M.E. DEC 11.1994 2 WHO COMPLETED CAUSE OF CEATH (ITEM 27) (Type, Print) 70/2000/EM. Hon 111 Penn Street, Baltimore, Maryland 21201 31. DATE FILED (Month, Day, Year) 12, REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DHMH-16 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

2	
death.	,
after	
24 riours	
within	
executed	
8	
certificate	
death	
the state	1
that	
requires	
AMP.	4
The	
IDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death.	
DING	

29b. SIGNATURE AND TITLE OF CERTIFIER

6 1994

31. DATE FILED (Month, Day,

O COMPLETEO CAUSE OF OEATH (TEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

RAHA

6

BE

9

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit Pages 1 2 3 s	iled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	ORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
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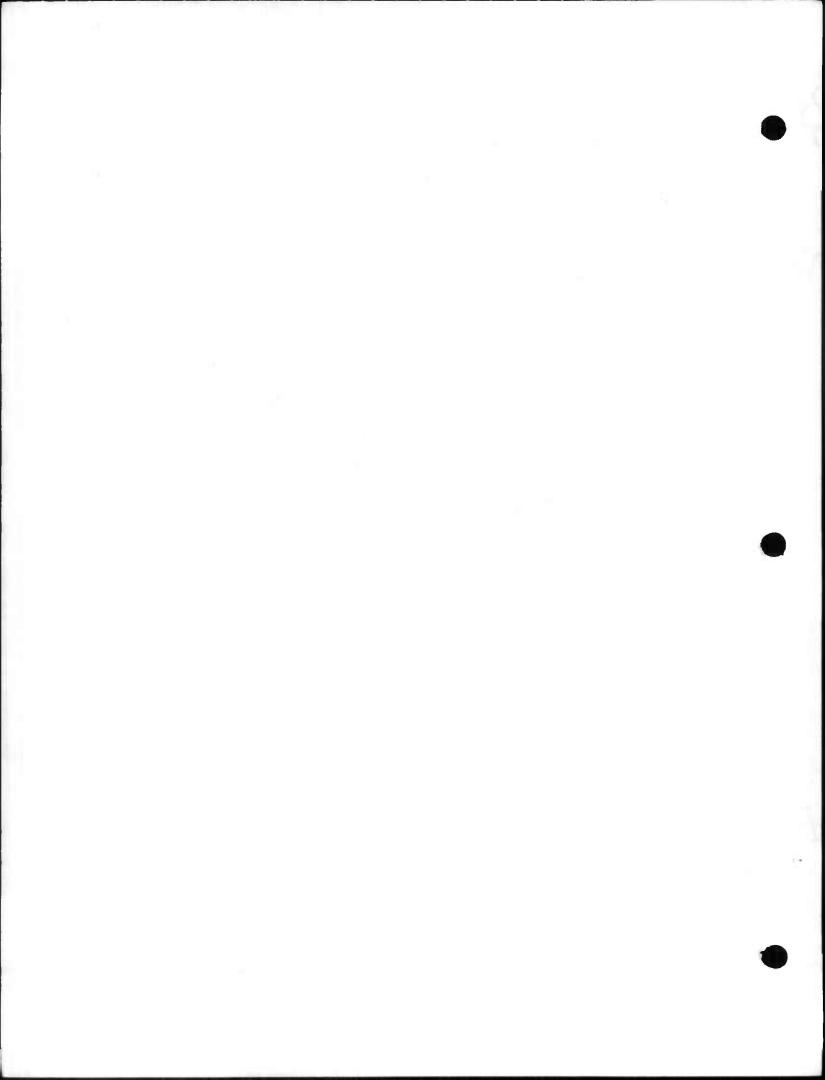
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH YEAR HOWARD HAMILTON DECEMBER 994 18.20 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) 7. DATE OF BIFTH (Morith, Day, Year) 6/6/190 IF UNDER 1 YEAR | IF UNDER 24 HRS. B. BIRTHPLACE (State or Fi 093-05-0230 Mary land DAYS HOURS 1 MM 2 - F hould 9s. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH St. Agnes Hospital Baltimore DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? MD Baltimore Arbutus 1 TES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 5557 Avenue U.S.A. 21227 regon WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or Noif yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 14. RACE - American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Pr 1 YES 2 NO Specify: 1 Never Married 2 Married BY IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced white COMPLETED 15. OECEDENT'S EOUCATION pecify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b, KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) Engineer 12 Company 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maide Joseph H. Hine BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Tow 2 Rambling Richard atonsville WD SISS8 20a, METHOD OF DISPOSITION
1

Burlel 2 □ Cremation 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State OATE 2 Cremation 3 🗆 pemetery, cremetory or other place.
Meadowride Memorial Park 12.17 Maryland Dorsey, 4 Donetlon 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY AMOROSE FUNETAL HOME, INC. 328 Sulphur Spring Rd., Arbutus, MD 21227 23. PART i. Phter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, Approximate shock, or haart feliure. List only one cause on each line. intarvai Betw IMMEDIATE CAUSE (Final Onset and Death disesse or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury OUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 -NO 1 YES 2 110 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TYES 2 DIE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. MANNER OF OEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Matural 1 YES 2 NO B 2 Accident 26e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide COMPLETED Could not be 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end manner as stated. 2 🗌 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

29d. DATE SIGNED (Month, Day, Year)

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		4. SOCIAL SECURITY NUMBER	5. SEX	- 1	E (In yrs. lest	MC MC	UNDER 1 YEAR		N. (Mo	E OF BIRTH orth, Day, Year)		SIRTHPL Country)	ACE (State or Fo	oreign
pino		212-07-4588 9a. FACILITY NAME (If not institution	1 XM 2		0)	YRS.	OITY YOUR	OR LOCATION O		/20/09	li come e			
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Page	DIRE		BALTIMORE	,		CA	OWN OR LOC	GEMERE					d. INSIDE CITY LIMITS?	- 1
permit	A	10e. STREET AND NUMBER						101, ZIP CODE			10g. CITIZEN	_	T COUNTRY?	-
in.	65	2825 LODGE FA						21219			U.S	.A.		
MARYLAND 21215-0020 retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1. notified at once.	BY FUN	11. MARITAL STATUS 1 X Never Merried 2 Merri 3 Widowed 4 Divorced	FORCE	ECEDENT EVER S? 1 V YE , GIVE WAR OR	S 2 N	IED O	II yea,	ECENDENT OF HIS specify Cuban, Ma ES 2 NO S	xican, Puart	SIN? (Specify Yea o Rican, etc.)	or No.— 14.	RACE — Black, W Specify:	American indi Inita, etc.	nn,
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ANE hos detache	MO	17. FATHER'S NAME (First, Middle,	Last)		ULI	THAI.		18. MOTHER'S		t, Middle, Malden		NEO		
YL dbe d be d	w I	WILLIAM STONI	E HANSON					JE	NNIE	SAUNDE	RS			
MARYLAND 2* retained by the hospital of 5 should be detached for notified at once.	TO B	19a. INFORMANT'S NAME (Type/Pr						t and Number or R					1000	
ay be r page 5		MRS. MARY JO A	A. PUNDT	12			AR LEA	AF COURT			CATION - City		1228	
FOR e 6 mg ector.		1X Buriel 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec						RIAL PAR			KRIDGE	or lown,	, State	}
BALTIMORE for death. Page 6 may to the funeral director, pag yal.		21. SIGNATURE OF FUNERAL SER	VICE LICENSEE	10			22. NAME	AND ADDRESS O	F FACILITY	• • • • • • • • • • • • • • • • • • • •				
3AL rr death rr death ral:		lino U	det	M	ms'			WILKENS				M	D 2122	9
		23. PART I. Enter the diseas ahock, or heart	ea, or complication	ona that caus	ed the dea	th. Do not							Approxim	ate
- 26		IMMEDIATE CAUSE (Final disease or condition											Onset and	Death
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C68760, executed with and complet to burial. cren	Z		C b. Me	tastat	ic Ca	rcino	na Of	Rladder					z yz	ac
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, P.O. BOX leath certificate be e attending physician rntal Hygiene prior to y, or other traun	SE	CAUSE (Disease or injury that initiated events		DUE TO (OR AS	A CONSEC	UENCE OF):								
S, P.O. B(death certificate attending physiental Hygiene pri	IH	resulting in death) LAST	d											
DS, I the deat of Mental dinjury,	- 11	PART II. Other aignificant on	nditipna contribu	ting to death	but not re	aultino in	he underly	Ino cause giver	in Part i.	24a, WAS AN	AUTOPSV	24b W	ERE AUTOPSY F	NDINGS
ORC that the bod by and in	ICAL								10 11	PERFOR	RMED?	AV	MILABLE PRIOR	TO
RECOR requires that requires that of Health an shows any	MED									1 123 2			DEATH?	NO
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ION OF NDING PHYSI T dearh with Is marked,	BY P	1 Natural 5 Pendi 2 Accident Invest	ng Igation	Month, Day, Year	,	INJUR		WORK? YES 2 NO						
S H D H S	8	3 Suicide 6 Could 4 Homicide determ	HOLDS 5	PLACE OF INJUI outlding, etc. (Sp	RY — At hon pecify)	ne, farm, stre	et, lactory, of	fice		CATION (Street in try or Town, State)		urel Rout	te Number,	
DIV OR AI DIRECT HOURS	COMPLET	29a. CERTIFIER (Check only	G PHYSICIAN: To the	best of my kno	owledge, das	th occurred	t the time, de	rta and place, and	dua to the	cause(a) and mai	nner as stated.			$\overline{}$
HOSPITAL FUNERAL WITHIN 72	OM	000)	XAMINER: On the bi									nse(s) su	nd manner aa s	tated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72	BE C	29b. SIGNATURE AND TITLE OF C	ERTIFIER		0			29c. LICENSE			29d. DATE SI	SNED (M	onth, Day, Year)	\neg
11+ P 2 3 W	2	30. NÁME AND APPRESS OF PER	J. Chr	mm	na()			リ ツー/	8298	3	12/	14/	94	
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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

a by the hospital or attending physician.	completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should al. cremation, or removal.	d at once.
within John Salter Death. Page o may be retained by the hospital or attending	cian and completely filled in by the funeral director, page 5 show for to burial, cremation, or removal,	ent, the medical examiner must be notifie
Nec.	this certificate has been signed by the attending physician and comi with the State Dept. of Health and Mental Hygiene prior to burial, c	d, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL ON ALTERNING PHISIOIAN, THE	TO THE FUNERAL DIRECTOR: After this certificate hat be filed within 72 hours after death with the State D	IMPORTANT: If item 28 is marked, or item 3

N. KIRI

31. DATE FILED (Month, Day, Year)
DEC 16 1994

1tem1/ 12-10-94 F				IENT OF H	FAITH AND	MENTAL HYGIEN		•		
1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last)		CE	RTIFIC	ATE OF	DEATH	REG. NO				_
Claire Heis	t					2. DATE OF DEATH DO DE ORMBELL	AY.	YEAR	3. TIME OF DEATH	6
4. SOCIAL SECURITY NUMBER 198-10-0119	5. SEX 6	AGE (In yrs. last t		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) DEC. 19, 19	`	S. BIRTI	IPLACE (State or For	
9e. FACILITY NAME (If not institution, give: Union Memoria		tal	96		n LOCATION OF D	EATH	_	JNTY OF D		
Union Memoria RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT MARYLAND			10c. CITY, TO	OWN OR LOCAT					10d. INSIDE CITY	_
				BALTIM	ORE ZIP CODE		I 40 . 00		1 YES 2	40
3900 N. CHARLES S	TREET - AI	PT-614		101.	212	218	10g. CI		S.A.	
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2 YES 1 YES, GIVE WAR OR DATES			ARMEO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Sp If yes, specify Cuban, Maxican, Puarto Rican, 1 YES 2 NO Specify:				or No-	14. RACI Blac Spec	E — American Indian k, White, etc.	
15. OECEDENT'S EDU (Specify only highest grade	CATION completed)	(Give	kind of work	JAL OCCUPATIO	N st of working	16b. KIND OF BUS	SINESS/IN	DUSTRY		
Elementary/Secondary (0-12) College (1-4 or 5 +)			OO NOT USO FOR EGISTE	RED NU	PRIVATE DUTY NURSE			RSE		
17. FATHER'S NAME (First, Middle, Lest) THOP THOMAS CAU	FIELD					ME (First, Middle, Maiden RET EAGEN	Surname)			
19a. INFORMANT'S NAME (Type/Print) LARRY FISHER						Route Number, City or Tow SOUTHAMPT			18966	
20s. METHOD OF DISPOSITION 1	noval from Stata	20b. PLACE AN cemetery, creme HOLY SE	D DATE OF DI atory or other p	ISPOSITION (Na	ne of ETERY	0ATE 20c. LO 12/19WYND		City or To	,	
21. SIGNATURE OF PUNERIAL SERVICE LA	Smith			22. NAME AN HUBBAR	D ADORESS OF FA					
23. PART I. Enter the diseases, or ehock, or heart fellure.	complications that of	ceueed the deet	th. Do not	enter the mo	te of dying, suc	h as cardiac or respi	retory a	rest,	Approximating Interval Bet	
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if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in death) LAST	c	OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):								
resulting in death) LAST	d									
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25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:		ОТ	heck only one)	5 D D 11					
27. MANNER OF DEATH 1 Natural 5 Pending	28a. DATE OF IN (Month, Day,	F INJURY 28b. TIME OF 28c. INJURY AT				28d. DESCRIBE HOW INJURY OCCURED				
2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	26s. PLACE OF I building, str	26s. PLACE OF INJURY — At home, term, street, factory, office building, stc. (Specify)					281. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
						to the cause(a) and men			and manner as etc.	rted.
29b. SIGNATURE AND TITLE OF CERTIFIE		17	MH		29c. LICENSE NUI	MBER	29d. DA	TE SIGNEO	(Month, Day, Year)	
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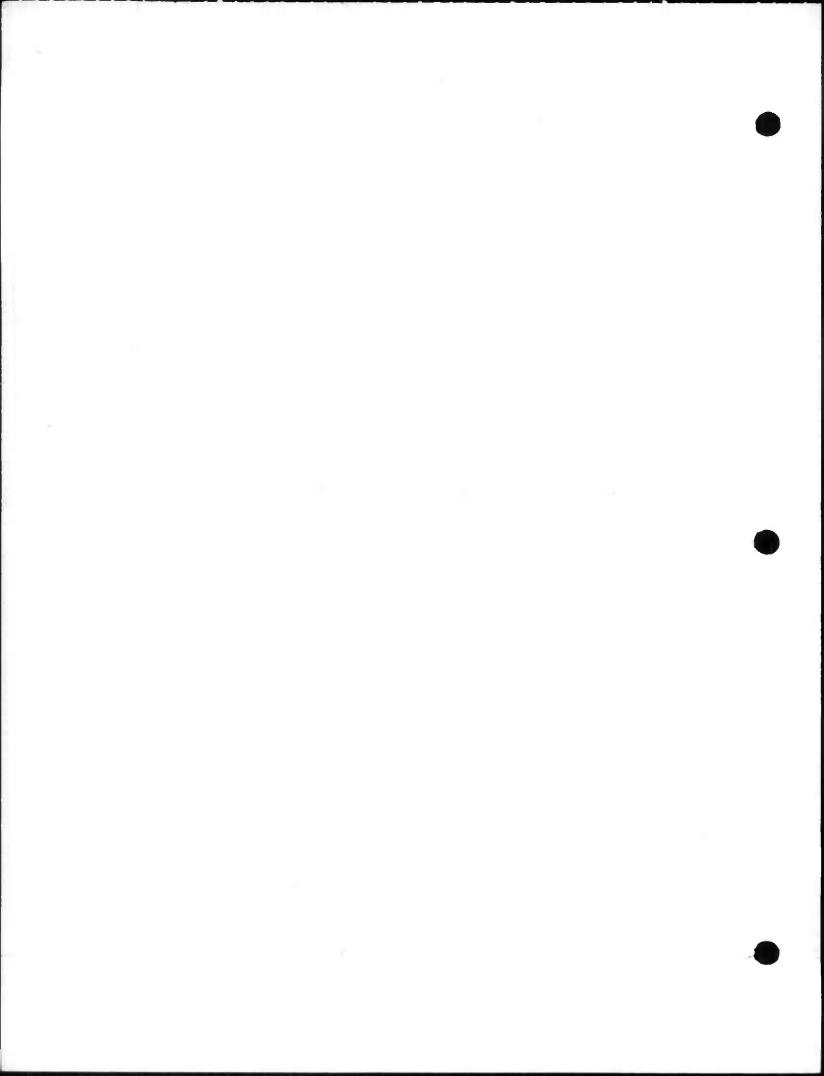
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		FOR STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTA	L HYGIEN REG. NO.	E		
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P	4	4. SOCIAL SECURITY NUMBER 217-16-6584	1 M 2 🗆 F		F UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		of BIRTH h, Day, Year) 20-2	_	BIRTHPLACE (St Country) Va	
2, 3 should	TOR	98. FACILITY NAME (If not institution, give sti	Ave		1	OR LOCATION OF DE	EATH		9c. COUNTY	OF DEATH	
t. Pages 1.	DIRECTOR	10s. STATE 10b. COUNTY		0	TOWN OR LOCAT	11				10d. INSI LIMI 1 YES	DE CITY
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ending physician. as the burial-transit permit. Pages 1.	PLETED BY	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO	If yes, sp	ENDENT OF HISPAN ecity Cuben, Mexics 2 NO Specify	n, Pusrto	Y? (Specify Yes Ricsn, etc.)	or No- 14.	RACE Americ Black, While, et Specify: Black	en Indien, ic.
Se att		15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5+)	18s. DECEDENT'S U (Give kind of wo life. Do NOT use	ork done during mo	ON sst of working		outher			
₩ 2 % E		17. FATHER'S NAME (First, Middle, Last) EMORY Has	Kins		-	18. MOTHER'S NA	ME (First, I	Middle, Maiden	Sumeme) Wley	,	
ay be retained the page 5 should the page 1 be notified	10	Anna Haskins		16	Shipley	and Number or Rural F	(atonso	illen	1 21	228
death. Page 6 may funeral director, p xaminer must		20a, METHOD OF DISPOSITION 1 N Burlel 2 Cremetion 3 Remo 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	val from Stats cen	PACE AND DATE OF etery, cremetory or oth	Sun For	est Vet	12/19/ CHITY	94 O	Wings	or Town, State	md
rs after death. Pag n by the funeral dir removal.		Fals 1	March	/	Yan	LEH.	2 00	alus	ih Ai	re Bal	4y Md 21215
the the		23. PART i. Enter the diseases, or cahock, or heart failure. IIMMEDIATE CAUSE (Final disease or condition resulting in death)	RESPIR	ATORY CONSEQUENCE OF	FAILVI	ZE				Inte On	proximate erval Between set and Daath
be execucian and or to bur aumatic	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	;	EL LU	NG	CARO	INOM) A (o MOS.
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uires that the deat signed by the att Health and Mental ws any injury,	FDICAL	PART II. Other algnificant conditions	contributing to death be	ut not reauiting in	tha underlying	g cause given in	Part i.	24a. WAS AN PERFOR 1 YES 2	MED?	AVAILABLI COMPLETI OF DEATH	
has been Dept. of 1 23 sho	AN: M	DID TOBACCO USE CONTR		F DEATH YES		UNCERTAIN	v 🗆			T TES	2 [] NO
IAN: Th tificate e State or Iten	PHYSICIAN:	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inputient 2 ER/Output		OTHER:	e 5 Residence	6 🗆 Othe	r (Specify)			
ig PHYSIC er this cer ath with th narked,	ву Рн	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY WO	URY AT PRICE 2 NO	28d. DES	CRIBE HOW II	NJURY OCCUR	ED	
ECTOR: Affice and a 28 is r	8	3 Suicide 6 Could not be 4 Homicide determined	26e. PLACE OF INJURY building, atc. (Speci	— At home, ferm, ati	rest, fectory, offic	•		ATION (Street a or Town, State)	nd Number or I	Rural Route Numb	er,
TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that TO THE FUNERAL DIRECTOR: After this certificate has been signed by be fled within 72 hours after death with the State Dept. of Health and IMPORTANT: If Item 28 is marked, or Item 23 shows any I	COMPLET		IAN: To the best of my knowle : On the bests of examination							euse(s) end msni	ner es stated.
TO THE HO TO THE FU be filed wit	TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	4918 mD			29c. LICENSE NUN	ABER 39		29d. DATE SI	GNED (Month, De	1y. Year)
			COLOGY (ENTE	R. 600 N	. WOLF	E ST., B	BALTI	MORE	, MO	21287	
		DEC1 6 1992	32. REGISTRAR'S SIGNA	r Revolut							



retained by the hospital or attending physician. 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the hours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	1 - FOR STATE OF MARYLAN	D / DEPARTA			MENTA	L HYGIEN					
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	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in you	7. DATE OF BIRTH 6. BIRTHPLACE (St				PLACE (State or Foreig	gn				
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	9a. FACILITY NAME (If not institution, give street and number)		. CITY, TOWN C	R LOCATION OF D		DC1 203.		TY OF D			
OR	3712 Keene Avenue Baltimore										
ក្ត	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY										
E			OWN OR LOCAT						10d. INSIDE CITY LIMITS?	.	
7	Maryland 100. STREET AND NUMBER	Ba	Baltimore 101. ZIP COOE					1 (X) YES			
RA	3712 Keene Avenue		"	21206			United States				
FUNERAL DIRECTOR	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.		13. WAS DEC	ENDENT OF HISPA	NIC ORIGI	N7 (Specify Yea				-	
	1 Never Merried 2 X Married FORCES? 1 YES 2		If yes, spe	city Cuben, Maxica 2 NO Specifi	in, Puerto		-	Black Specifi	— American Indian, , White, atc.		
ВУ	3 Wildowed 4 Divorced			×	,.			аресл	White		
Ħ	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	e. DECEDENT'S USI	done during mo:	N st of working	16	. KINO OF BUS	INESS/IND	USTRY			
۳	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use re					_			- 1	
COMPLETED	12 17. FATHER'S NAME (First, Middle, Last)	Clerical					1roa	d			
				18. MOTHER'S NA			Surname)				
BE	John Huber 19a. INFORMANT'S NAME (Type/Print)	T 405 MAN INO 45	DB500 (0)	France			-				
2	Mr. Joseph F. Haubner					,			1206		
	20a. METHOD OF DISPOSITION	ACEAND DATE OF D		Avenue	Dd	timore	CATION —	_	1206		
	1 ☐ Burisi 2 💢 Cremation 3 ☐ Removal from State cemeter	v. cremetory or other	plece)								
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Z	top Servic		D ADDRESS OF FA		4 1 10	wson.	Mai	ryland	\dashv	
	Maylo T. Barapa	avoyna		ard J. I						- 1	
	1.03 1.	- double Double	5305	Harford	Roa	id Bal	timo	ce.			
	23. PART I. Enter the disessea, or complications that caused the desth. Do not enter the mode of dying, such as cerdisc or respiratory errest, shock, or heart fallure. List only one cause on each line. iMMEDIATE CAUSE (Final										
	iMMEDIATE CAUSE (Final disease or condition										
	reaulting in death)										
_	DUE TO (OR AS A CONSEQUENCE OF):										
<u> </u>	Sequentisily list conditions, if sny, leading to immediate										
8	CAUSE (Disease or injury									.	
틸	that Initiated eventa DUE TO (OR AS A CO	NSEQUENCE OF):									
CERTIFICATION	resulting in death) LAST										
	PART II. Other significant conditions contributing to death but r	not resulting in ti	he underiving	Cause given in	Part I	24s. WAS AN	ALITOPEV	246	WERE AUTOPSY FINDS	2014	
정		To Tourist III	no underlying	oudso given in	Y and to	PERFOR		240.	AVAILABLE PRIOR TO	200	
						1 TYES 2	□ NO		OF DEATH?	~	
Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF D	SEATU VEC		UNCERTAII					1 TYES 2 NO	- 1	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL 26.	PLACE OF DEATH (UNCERIAII	ч Ц						
SIC	EXAMINER? 1 ☐ YES 2 ☐ NO 1 ☐ Inpatient 2 ☐ ER/Outpatie		THER:	5 Residence	a [] 0#6	e (Specific)				\neg	
ξ	27. MANNER OF DEATH 28s. DATE OF INJURY	28b. TIME O	F 28c. INJU	JRY AT	-	SCRIBE HOW IN	JURY OCC	UREO		\neg	
BY	1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation	INJURY		ES 2 NO						ı	
	3 Sulcide a Could not be 28e. PLACE OF INJURY — building, etc. (Specify)	At home, term, atres	t, tactory, office		281. LOC	CATION (Street a or Town, State)	nd Number	or Rural A	oute Number,		
OMPLETED	4 Homicide determined				City	or lown, State)				_ [
2	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge	e, death occurred at	t the time, date	and place, and due	to the ca	use(s) and man	ner se state	d.		\neg	
ŏ.	one) 2 MEDICAL EXAMINED. On the besis of examination en								end manner ae state	d.	
91	96. SIGNATURE AND TITLE OF CERTIFIER		, 1	29c. LICENSE NUI					(Month, Day, Year)	\dashv	
1	Van Conn	M	クー	1340.					15-94		
٩٧	20 ME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF DEATH	(ITEM 27) (Type, Prin		10	_				- /	-	
}	Gent Jumantan 1881. P. 11	Bal time	te n	10 21	239					- 1	
	31. THE HOLE (AGUIT DISA) SULVA MEMEGISTRAN'S SIGNATUR	RE								\dashv	
	0	A.								- 1	

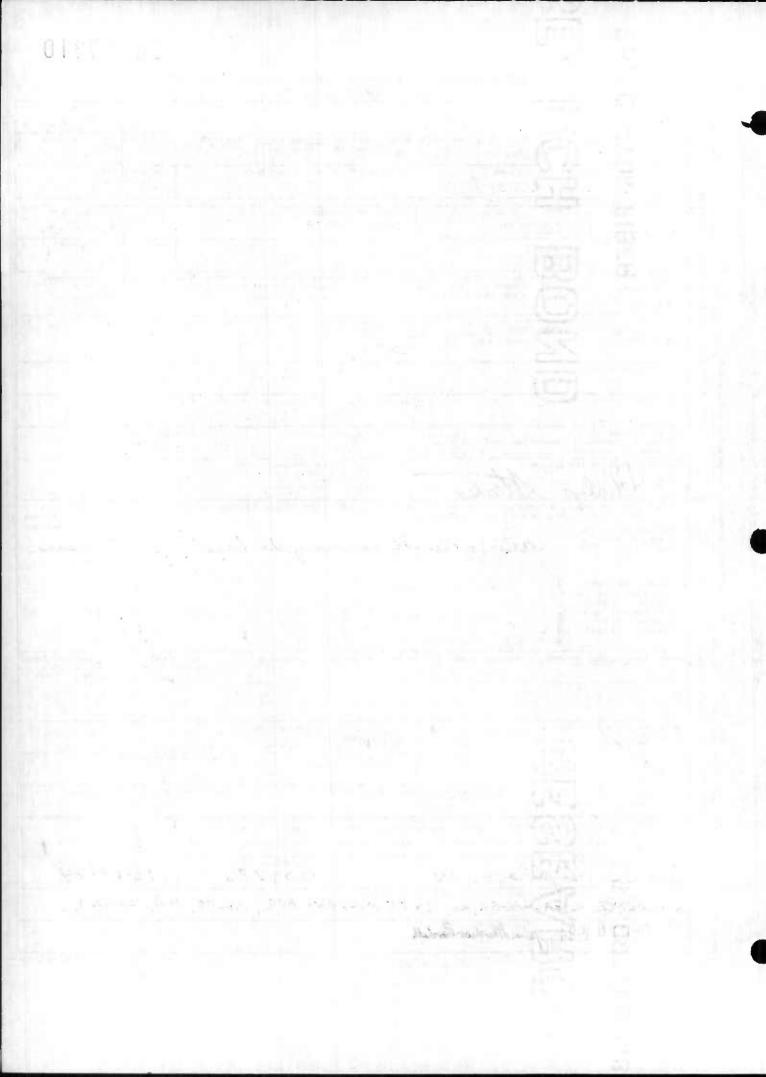
BALTIMORE, MARYLAND 21215-0020	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physici	
	nours after dea	
BOX 68760	cate be executed with	
DIVISION OF VITAL RECORDS, P.O. BOX 68760	requires that the death certifi	

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with about a fer death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatte event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPART			MENTAL HYGIE						
	1. DECEDENT'S NAME (FIRST, MIDDIE, Last Margaret	H. HALE	34			2. DATE OF DEATH MONTH /2		94	3. TIME OF DEATH 1:08 Pm M			
	4. SOCIAL SECURITY NUMBER 215-34-6545 90. FACILITY NAME (If not institution, give	1 □ M 2 🚰 F 9	1 M 2 学 91 YRS. MONTHS DAYS HOURS MIN. JUNE 14, I									
CTOR	CHARLESTOWN CARE		EATH	BALTIMORE								
DIRECTOR		ALTIMORE		TOWN OR LOCAT				10d. INSIDE CITY LIMITS? 1 YES 20 NO				
FUNERAL	713 MAIDEN CHO				21228		Ţ	10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
BY	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 2NO	II yes, sp		NIC ORIGIN? (Specify on, Puarto Rican, etc.) y:		14. RACE Black Speci	, White, etc.			
COMPLETED	15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12)	UCATION de completed) College (1-4 or 5+)	Ille. Do NOT use	rk done during mo	st of working	16b. KIND OF	EALTH (
BE COM	17. FATHER'S NAME (First, Middle, Lest) HENRY HELI	len Sumeme)										
TO B	19a. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN H. HALEY P.O. BOX 316, ROYAL OAK, MARYLAND 21662—0316											
	20b. PLACE AND DATE OF DISPOSITION DATE 20c. LOCATION - City or Town, State Commetter of the pieces DULANEY VALLEY MEMORIAL 12-15 COCKEYSVILLE, MD.											
	STERLING ASHTON FUNERAL HOME, INC. 736 EDMONDSON AVNUE, BALTIMORE, MD. 21228											
CERTIFICATION	23. PART i. Enter the dieceses, or compilections that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Attack of the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on asch line. But to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):											
MEDICAL	PART ii. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO								WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp		OTHER:	ACE OF DEATH (Ch							
ВУ РНУ	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME	OF 28c. INJ		6 Other (Specify) 28d. DESCRIBE HO	W INJURY OC	CURED				
	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY	— At home, term, str	eet, factory, offic	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
COMPLETED	onel	SICIAN: To the best of my knowledge. On the basis of examination) end manner as stated.			
TO BE	SIGNATURE AND TITLE OF CERTIFIC	alloger, r	Ø		DO 17	MBER 786	29d. DATE SIGNED (Month, Day, Year) ▶/2-/3-94					
	30. NAME AND ADDRESS OF PERSON W	quager, MD,	34551	NI-KEY	15 AVE	BALTO	MD,	213	29			
	31. DATE DE COT 67 1994	July Wandler	trung				THE					



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		Pages
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020	after death. Page 6 may be retained by the hospital or attending physician.	filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
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121	or after	use a
3	7	Po
BALTIMORE, MARYLAND 21215-0020	the hospit	letached
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MAR	etaine	shoul
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Ш	A	bed
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Σ	Se	P
FTA	death. P	funeral
B	after	by the
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6		filled

TO BE COMPLETED BY FUNERAL DIRECTOR

Add. Info.	FilmG718	12/17/	94 ka	.m								
FOR STATE REGISTRAR	STATE OF I	MARYLAND C	DEPAR					MENTA	L HYGIEN			
1. DECEDENT'S NAME (First, Middle, Lest)	D - 1 1								YEAR 94	3. TIME OF DEATH		
4. SOCIAL SECURITY NUMBER	Bobby 5. SEX	nes	R 1 YEAR		2.700				,			
TO THE SECOND PROPERTY OF THE SECOND PROPERTY	or react (in year birthou					HOURS	24 HRS.		OF BIRTH , Day, Year)		6. BIRTH	IPLACE (State or Foreign
	1 M 2 - F		YRS.			4	21	81	23/	94	Mar	vland
9e. FACILITY NAME (If not institution, give :	street end number)			9b. CIT	Y, TOWN O	R LOCATIO	ON OF OE	EATH	1	9c. COU	NTY OF O	EATH
Prince George Ho	ospital C	enter			Chev	erly				Pri	nce	George's
10e. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN	OR LOCATI	ON						10d. INSIDE CITY
Md.	Prince Ge	orcola		u - 4 - 1	l a m d							LIMITS7
10e. STREET AND NUMBER	TINCE GE	orke s	1	uit		ZIP CODE				I son CIT	ZEN OF Y	WHAT COUNTRY?
0.1.0.0					101.	211 0000				log. Cri	ZEN OF V	THAT COUNTRY
2400 Lewis Avenu						2074				US	Δ	
11. MARITAL STATUS	12. WAS DECEDEN FORCES? 1	T EVER IN U.S. AI		13.	WAS DECE	NDENT O	F HISPAN	IC ORIGIN	? (Specify Ye	s or No-	14. RACE	— American Indian, t, White, etc.
1 Never Married 2 Merried 3 Wildowed 4 Divorced	IF YES, GIVE V				1 YES				womi, arc.)		Speci	
3 Wildwed 4 Divoled												Black
15. DECEDENT'S EDU (Specify only highest grade	CATION		ECEDENT'S					16b	KIND OF BU	SINESS/IND	USTRY	
Elementary/Secondary (0-12)	College (1-4 or 5	life	Bive kind of a Do NOT us	work done se retired.)	during mos	t of working	g					
0		" l		none	2				no	ne		
17. FATHER'S NAME (First, Middle, Last)						10 MOTH	ED'C MA	ME (E)	Aiddle, Maider			
	Dickey									,		
	DICKEY					_			tte H			
19a. INFORMANT'S NAME (Type/Print)		19							per, City or Tov			
Mother			2400	Lev	vis A	venu	e, S	Suit1	and,	Md. 2	0746	
4 Donation 5XX other (Specify) D.\(\) 21. SIGNATURE OF FUNERAL SERVICE LICE				22.	NAME AN	DADDRES	S OF FA	CILITY				
23. PART I. Enter tha diseesea, preshock, present fellura. IMMEDIATE CAUSE (Final disease or condition resulting in daeth)	Liet Dnly Dna cau	t coused the desa Dn each line	a,									Approximats Interval Between Oneat and Death
Sequentially list conditiona, if sny, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST	c	OR AS A CONSE			200	V						
PART II. Other algorificent condition	s contributing to	deeth but npt	resulting	in the u	nderlylng	ceuse g	iven in	Part I.	24e. WAS AMPERFO	RMED?	246	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
25. WAS CASE REFERRED TO MEDICAL												
EXAMINER?	HOSPITAL:		Т	OTHE		CE OF DE	ATH (Che	ock only on	0)			
1 TYES 2 NO	1 🗆 Inpatient 2	ER/Outpatient 3	□ DOA		rsing Home	5 🗆 Res	sidence	6 🗆 Other	(Specify)			
27. MANNER OF DEATH	28e. DATE OF (Month, D		26b. TIM	E OF URY	28c. INJU WOR	RY AT		28d. DES	CRIBE HOW	NJURY OC	CURED	
1 Netural 5 Pending Investigation	(morali, D	-n 100/	INIJ	M		IK? ES 2 🗌	NO					
2 0 8-1-14-	26e. PLACE O	F INJURY — At he	me, ferm	treet for		-		261 100	ATION /S	and Monte-	or Down !	loute Member
3 Suicide 6 Could not be determined	building,	etc. (Specify)	A.IV, 181111, 1	niest, ISC	tory, ornice			City o	ATION (Street or Town, State	arid Number)	or Hurai F	oute Number,
29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI) and manner es stated.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the stern death. Page 6 may be retained by the above 10 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filest in by the funeral director, page 5 should be detached filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

296. SIGNATURE AND TITLE OF CERTIFIER Zenaida P. 1 31. DATE FILDECT POTO 1994

29c, LICENSE NUMBER 22 Prince

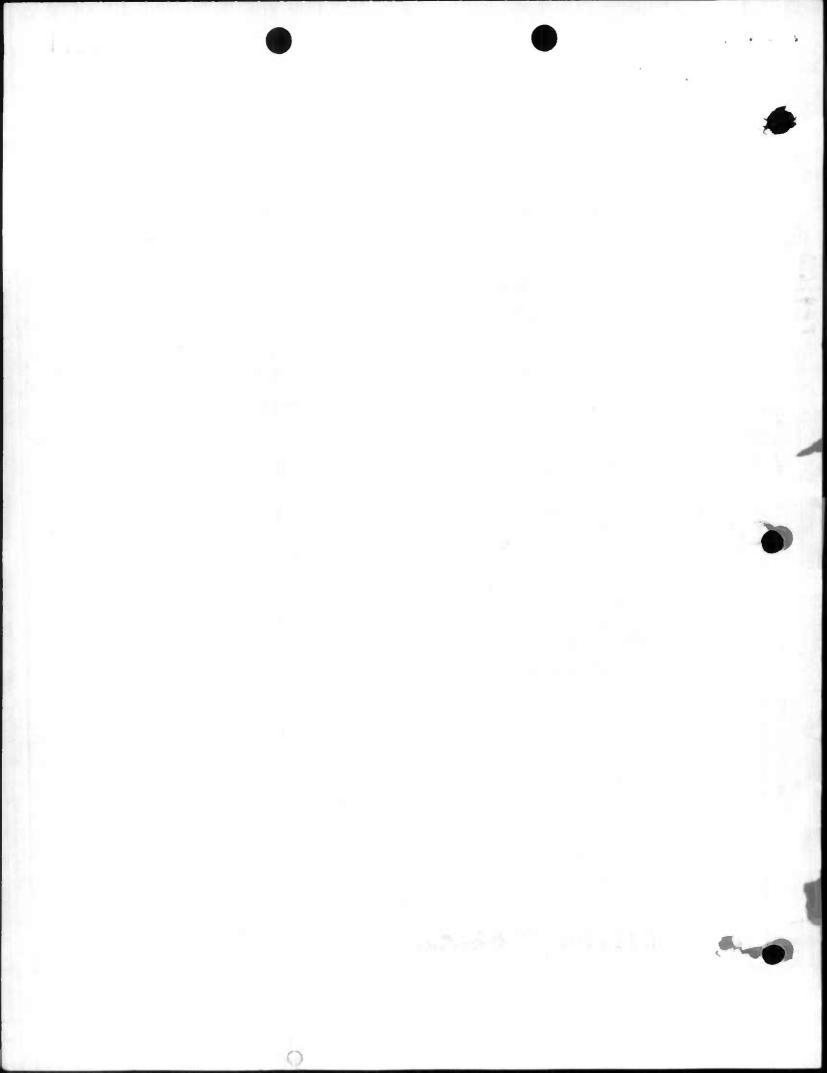
29d. DATE SIGNED (Month, Dey, Year)

8/23/94 23/

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1:00 M M 12

Hospital



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TENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.	-	ď.
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CIAN: The law requires that the dea	i	after
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CIAN: The law requires that the dea	P	Ñ
CIAN: The law requires that the dea	ŝ	within
CIAN: The law requires that the dea		executed
CIAN: The law requires that the dea	ì	2
CIAN: The law requires that the dea		certificate
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TENDING F	•	PHYSICIAN:
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TO BE COMPLETED BY PHYSICIAN; MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020	CIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ertificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	medical examiner must be notified at once.
IVISION OF VITAL RECORDS, P.O. BOX 68760,	TD HE HOSPITY OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24	TO THE TRANSPILL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the filler with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: IT They 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR		STATE OF I	MARYLANI) / DEPAI CERTIF	RTMENT	OF H	IEALTH AND I	MENT	AL HYGIEN REG. NO.	E		
18	1. DECEDENT'S NAME (First,		uel	TT- 1					2. DAT	TE OF DEATH	¥0.4	YEAR 3.	TIME OF DEATH
	Martin	Halpe						9, 1	194	55%	5112 8. M		
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE 132 20 7454 1√2√M 2 □ F				lest birthday)	IF UNDER	1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mo	E OF BIRTH rith, Day, Year)		8. BIRTHPL Country)	ACE (State or Foreign
d	9e. FACILITY NAME (If not institution, give street and number)				7 YRS.					. 22,19	7		York
DIRECTOR	10712 Woodso	<u></u>	96. COUNTY OF Silver Spring Montgo					1111					
EC	10a. STATE	10b. COUNTY	,		10c. CI1	ry, TOWN C	R LOCAT	ION	_			10	d. INSIDE CITY
DIR.	Maryland	Mont	gomery		Si	lver	Spr	ing					LIMITS? YES 2 NO
3AL	10e. STREET AND NUMBER						101	. ZIP CODE			10g. CIT	IZEN OF WHA	T COUNTRY?
FUNERAL	10712 Woods	dale D						20901				USA	
84	11. MARITAL STATUS 1 Never Married MM Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVEN FORCES? 1 IN THE PRES. GIVE WAR OF THE P				2 NO If yes, specify Cuban, Mexican, Puerto Rican, etc.) Bis					Black, V	American Indian, White White		
皚	15. DECE (Specify only	DENT'S EDUC highest grade	CATION completed)	16a	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working				10	b. KIND OF BUS	INESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0-	-)	Rabbi				Jewish Congregation			ion			
Š	17. FATHER'S NAME (First, Mid				18. MOTHER'S NA	ME (First	, Middle, Malden	Surname)					
BE (William Halpern							Shirley	Coh	en			
5	19a. INFORMANT'S NAME (Type/Print)				19b. MAJLING	ADDRESS	(Street a	nd Number or Rural I	Route Nu	mber, City or Town	n, State, Zi	p Code)	
-	Rose Halperr	100	Same as item 10a-f										
1	20a, METHOD OF DISPOSITIO	3 🗆 Hemo	vel from State	20b. PLA cemetery Kin	20b. PLACE AND DATE OF DISPOSITION (Name pl complety, crematory or other place) Mem Gardens 12/11 Falls Church, Virgin								
-	21. BIGNATURE OF FUNERAL	LE	L Ven	la	-	4	72 N		igto	n St Fa	lls		h,VA 22046
A - 41	23. PART I. Enter the dis shock, or ha	art fallure, L	List Dnly Dna ceu	se on eech	lga.	,			h as ca	rdiec or reapi	ratory ar	rest,	Approximate Interval Between Onset and Death
	disease or condition resulting in death)	.		asta		Mela	9-20	lleg					1 412.
_		_	DUE TO	(OR AS A CON	SEOUENCE O	F):							
CATIO	Sequantially list condition if any, leading to immedicause. Entar UNDERLYIN	late IG	DUE TO	(OR AS A CON	SEQUENCE O	F):							
CERTIFICATION	CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST												
CIAN: MEDICAL C	PART II, Other significant conditions contributing to death but not resulting Poly cy them a Vern Tepatitis C					in tha undarlying cause given in Part i			Part I.	24a. WAS AN PERFOR	MED?	AM CC OF	ERE AUTOPSY FINDINGS ARABLE PRIOR TO MPLETION DF CAUSE DEATH? YES 2 NO
Z 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)													

1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA | 4 | Nursing Home 5 | Residence 8 | Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK?
1 YES 2 NO 26b. TIME OF INJURY 1 | Natural 2 | Accident 28e. PLACE OF INJURY — At home, term, street, tectory, office building, atc. (Specify) 3 Suicide
4 Homicide 6 Could not be determined 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

296. SIGNATURE AND TITLE OF CENTIFIER 29d. DATE SIGNED (Month, Day, Year) 011438 12/10/14

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Mr. S. SCHNIZIDIZK 12001 FERRARA AVE

12. REGISTHAR'S SHEATURE

229-26-4054 1X M 2 | F YRS. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH THE JOHNS HOPKINS HOSPITAL DIRECTOR BALTIMORE CITY RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION N/A Maryland Baltimore permit. 10e. STREET AND NUMBER FUNERAL 10f ZIP CODE 964 N. Chester Street after death, Page 6 may be retained by the hospital or attending physician. On the funeral director, page 5 should be detached for use as the burial-transit 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2X NO IF YES, GIVE WAR OR DATES BALTIMORE, MARYLAND 21215-0020 1 Never Merried 2 Merried 1 YES 2 XNO Specify BY 3 Wildowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only hi Ē Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Unknown Laborer 17. FATHER'S NAME (First, Middle, Last) Norman Hall notified at BE 19e. INFORMANT'S NAME (Type/Print) 2 Bernice Coston 964 N. Chester Street must be 20a. METHOD OF DISPOSITION

1X Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of Zion 4 ☐ Donation 5 ☐ Other (Specify) Cemetery the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Chatman-Harris Herris 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, ysician and completely filled in by prior to burlal, cremation, or remo shock, or heart failure. List only one cause on each line IMMEDIATE CAUSE (Finel Sepsis
DUE TO (OR AS A CONSEQUENCE OF): disease or condition event. resulting in deeth) DIVISION OF VITAL RECORDS, P.O. BOX 68760 Urinary traumatic DUE TO (OR AS A CONSEQUENCE OF) Infection CERTIFICATION Sequentially list conditions, if any, leeding to immediate been signed by the attending physician it, of Health and Mental Hygiene prior to I tal Vein Throm bosis DUE TO (OR AS A CONSEQUENCE OF): cause. Enter UNDERLYING CAUSE (Disease or Injury other t thet initieted events resulting in deeth) LAST irchosis 6 PART ii. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert i. MEDICAL Chronic Obstructive Lung shows any ular accident DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES 🗵 NO 🗌 UNCERTAIN 🗆 PHYSICIAN: has be Dept. OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item DIRECTOR: After this certificate hours after death with the State HOSPITAL: 1 YES 2 NO 1 12 Inpatient 2 - ER/Outpatient 3 - DOA marked, or 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Yeer) 28c. INJURY AT 1 Natural 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Suicida 99 6 Could not be COMPLETED 4 Homicide 28 determined Item 1 😿 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(e) end manner ee stated. THE HOSPITAL ITHE FUNERAL [TO THE HOSPITAL TO THE FUNERAL C be filed within 72 h (Check only one) 2 MEDICAL EXAMINER: On the beals of * 2 JOHN C. N WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type ISAAC M.D. 600 n. WO[600 n. WOLFE STREET REGISTRAR'S SIGNATURE

STATE REGISTRAR

PERSHING

4. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Last)

94 37313

REG NO

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR

HALL

6. AGE (in vrs. last birthday)

2. DATE OF DEATH 3. TIME OF CEATH DECEMBER 1994 8:55 AM 7. DATE OF BIRTH (Month, Day, Ybar) IF UNDER 24 HRS. B. BIRTHPLACE (State or Foreign 25,1918 N. Carolina Auq. 9c. COUNTY OF DEATH N/A 10d. INSIDE CITY 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? USA 21205 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuben, Mexican, Puerio Rican, etc.) 14. RACE — American Indian, Black, White, etc. Specify: Black 16b. KIND OF BUSINESS/INDUSTRY 18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Bizzell 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 21205 Baltimore, Maryland 12/14/94
Baltimore, Mar Maryland 22. NAME AND ADDRESS OF FACILITY 5240 Reisterstown Road F/H Baltimore, Md21215 intarvai Batween Onset and Death DAYS 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 58 YES 2 1 NO 1 YES 2 NO 4 - Nursing Home 5 - Residence 6 - Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED 28t. LOCATION (Street end Number or Rural Route Number, City or Town. State) ation end/or investigation, in my opinion, death occured at the time, date and place, end due to the cause(e) end manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year, BALTIMORE, MD 21287

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

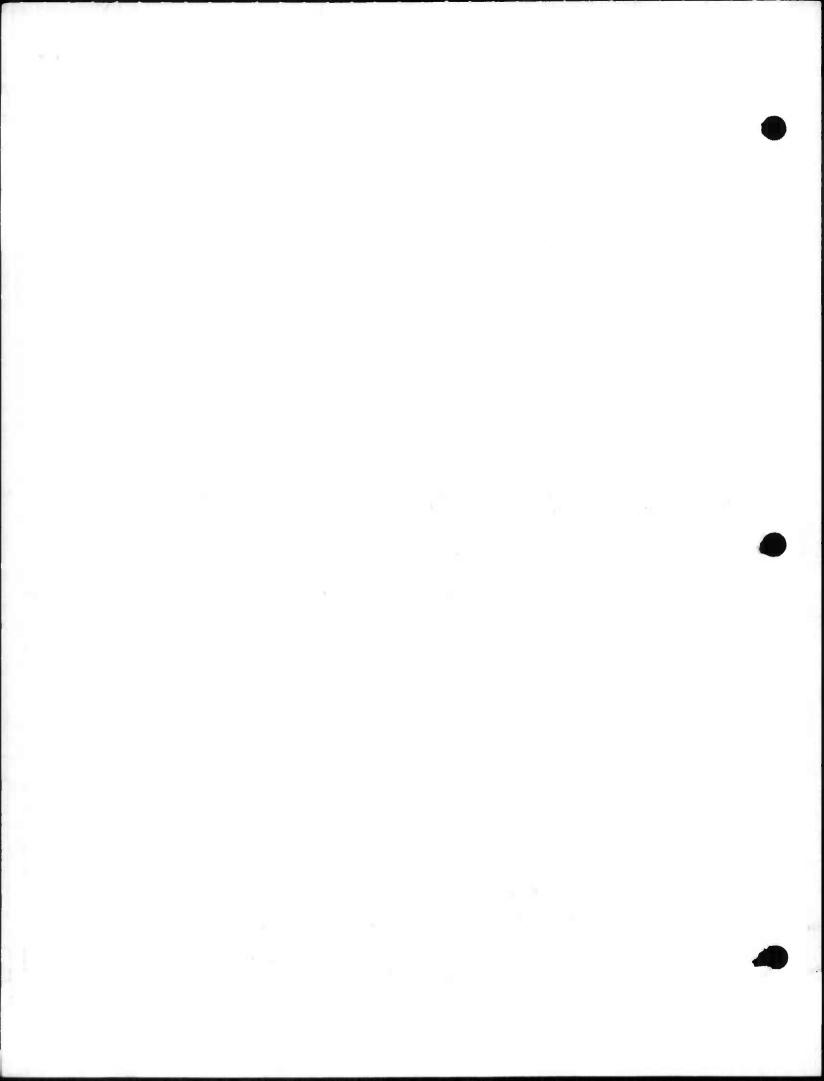
		i i	1. DECEDENT'S NAME (First, Middle, Last)							2.	DATE OF DEATH		13	TIME OF DEATH	
			Kevin S.	н	udson						MONTH E	DAY 1 O	YEAR		
		3	4. SOCIAL SECURITY NUMBER		AGE (In yrs. lesi	birtnday)	IF UNDER 1	YEAR	IF UNDER 24		Dec 06			0 2 4 5 VCE (State or Foreign	
		- 5	220-74-1056	1 X M 2 - F	36	YAS.	MONTHS	DAYS			(Month, Day, Year)		Country)		1
	pjnoqs		9a. FACILITY NAME (If not institution, give st				Sh CITY	TOWAL O	R LOCATION	I DE DEATH	-Ph 28,		TY OF DEAT	YLAND	
	3 Sh	œ				- 1	50. CITI,						1	н	
1. 2.		5	Shock Trauma C	enter				Ba	ltimo	ore		/	N/A		_
		DIRECTOR	10a. STATE 10b. COUNTY			10c. CITY	, TOWN OF	R LOCAT	ION				to	d. INSIDE CITY	_
	2.	5	MARYLAND	V/A				BA	LTII	MARE	CIT	ν	1	LIMITS?	
	Sermi	AL	10e. STREET AND NUMBER						ZIP CODE	10170		10g. CITIZ		T COUNTRY?	
	prysician. burlal-transit permit. Pages	FUNERAL	7024 N. ALTER	STREET					2	120	7		USF	}.	
0	sician al-tra	5	11. MARITAL STATUS	12. WAS DECEDENT EV							RIGIN? (Specify Ye	-	14. RACE	American Indian.	
-0050	pud pri	ВУ Б	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1		0			2 NO		erto Rican, etc.)		Black, W Specify:	hita, atc.	
5-	as the												BLF	CK	
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21	for 1	ا ت	Elementary/Secondary (0-12)	College (1-4 or 5+)		Do NOT use	,	Fr. A	4541		JOHNA	1V's	AU	T'A	
S	detached once.	COMPL	12TH GRADE		CF	t/<	SAL	-65/				1	714	10	
LA	be detach		t7. FATHER'S NAME (First, Middle, Last)	HUDSO	SAL						First, Middle, Malder	Surname)	01		
Œ	ed at	8	11711/0-2	7141000						RBAI		GAI	MBY		
MA	5 should be	2	19a. INFORMANT'S NAME (Type/Print)	HUDSON	198	MAILING	ADDRESS	(Street ar	nd Number or	Rural Route	Number, Cify or Tov	vn, State, Zip (. 7 . 7	
ш			0111001110	TUDSON	7	0.24	Nil	147	EK S	Sti, K	3ALTIM	ORE, M		1207	
ORI	ector, p		20e, METHOD OF DISPOSITION 1) Burlel 2 Cremetion 3 Remo	oval from State	20b. PLACE A cemetery, crer			TION (Na	ma of		OATE 20c. LC	CATION - C			
TIM	direc direc	1	Donetion Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE	ENGER	KING A	1EMOI		PAR	KK	12-	-13-94 W	DODLA	twn,	MARYLAN	0
E	aner ocaun. Fage of may be by the funeral director, page smoval.		21. SIGNATURE OF PUNCHAL SERVICE LIC	CHSEE)			22. N	SFP.	O ADDRESS	OF FACILITY BRAIN	N.TR. FU	NERA	74 He	ME,P.A	0
3AI	al. fu		Machil	10		/	19	131	J. BAI	TIMAR	F ST. B	ALTA.	MD.	21223	
_	d in by the or remova		23. PART I. Enter tha diseases, or c ahock, or haart failura. I	omplications that ca	used the de	th. Do n	ot entar t	the mod	de ot dying	, such as	cardiac or reap	iratory arre	st,	Approximate	
	filled in the on, or rer		IMMEDIATE CAUSE (Final	list only ona cause	on aach lina.									Interval Batwe Onset and Da	
			disease or condition resulting in death)	BLUVT	FOR	43-1	DIV1	Rule	55 TO	1400	D				
09	completely fille fal, cremation.		Todaming in addition	OUE TO (OR	AS A CONSEC				10						
68760		Z	Sequentially list conditions,	b											
×	3 0 0	RTIFICATION	if any, leading to immediata	PO) OT 3UO	AS A CONSEC	UENCE OF):								
ВО	physician ne prior to	2	cause. Entar UNDERLYING CAUSE (Disease or Injury						-						
0	othe othe	늗	that initiated events resulting in death) LAST	DUE TO (OR	AS A CONSEO	UENCE OF):								
Δ.		CER	tosoiting in death) CAST	l											
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	th and in	DICAL									PERFO	RMED?	AW	ILABLE PRIOR TO MPLETION OF CAUSE	
00	signed Health a	Q P									1 VES	2 NO	OF	DEATH?	
RE	been of the		DID TOBACCO USE CONTR	IDLITE TO CALIS	E OE DEAT	TU VE	c \square N	io ita	LINICE	DTAIL F	,		17	YES 2 NO	
7	State Dept. of	AN:	25. WAS CASE REFERRED TO MEDICAL	ABOTE TO CAUS			H (Check or		UNCE	RTAIN [
VITAL	certificate has the State Dep	SICI	EXAMINER?	HOSPITAL:			OTHER:	:		77.7					_
FV	the the	> II	27. MANNER OF DEATH	1 ☐ Inpetient 2 X ER		28b, TIME		ng Home 28c. INJU			Other (Specify)	IN HERY COCK	IDEO.		_
OF	fter this clear with marked,	H	1 Netural 5 Pending	(Month, Day, Y	94	2030	JRY	WOF	ES 2 N			BUNTE	- 1		
NO	After death	B	2 Accident Investigation 3 Suicide & Could not be	28e. PLACE OF IN.					20 101		LOCATION (Street			Mumber	41
S	after d	回	4 Homicide 8 Could not be	building, atc.	(Specify)	A	Subl	1			City or Town, State,)		-	71
DIVISION	DIRECTOR. After this certificate has been signed by hours after death with the State Dept. of Health an item 28 is marked, or item 23 shows any	ш	29a. CERTIFIER		िट्टा					6				DUTINORS	7
		MPL	(Check only												
	TO - 44	COM	2 MEOICAL EXAMINER	. Oil live beele of axamil	necton eng/or in	ivestigation	, in my opi	mion, de	enth occured	at the time,	gets and place, ar	nd due to the	cause(a) en	d manner ee stated.	
0	A BEC	U 11													
	HE FUNERAL Hed within 72 I		296. SIGNATURE AND TITLE OF CERTIFIER	1 100				T	29c. LICENS	E NUMBER				nth, Day, Year)	
i,	TO THE FUNERAL De filed within 72 IMPORTANT: If	.O BE (29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	Ybell						E NUMBER	Ξ			nth. Day, Year) 7 1994	

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland

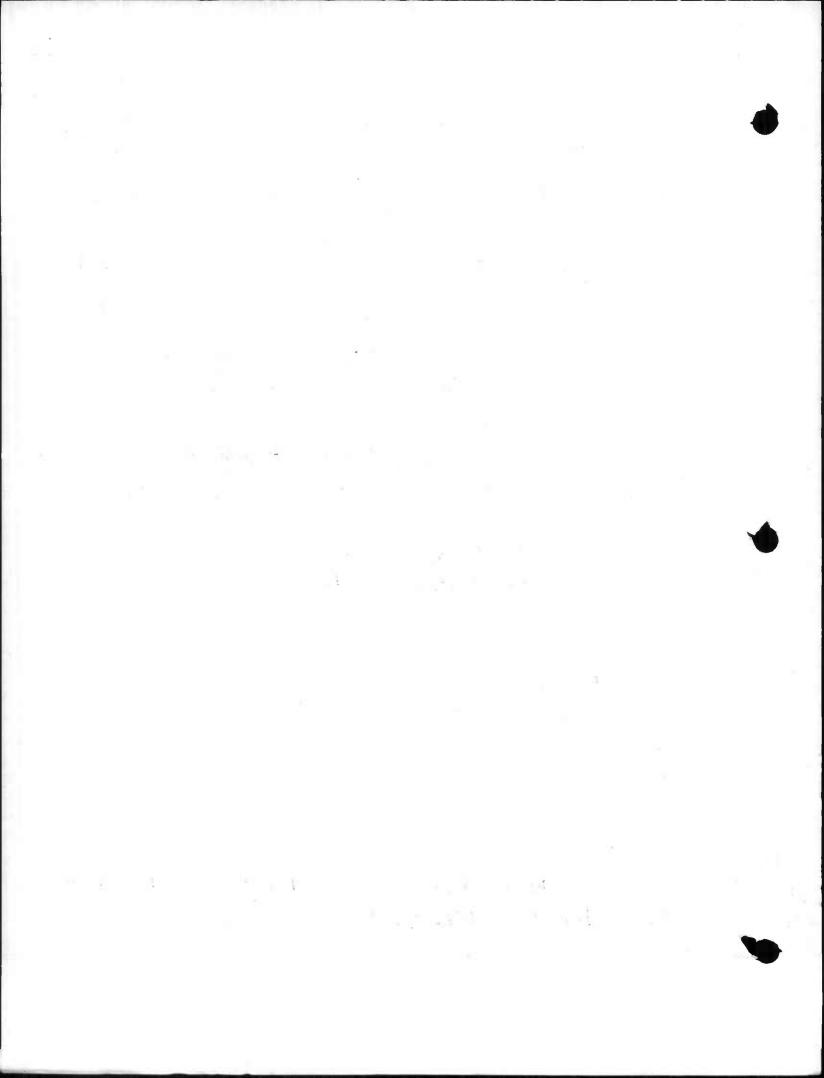
	3 should	
	Pages 1.2	
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attending (se as the	
ospital or	- 32	
d by the h	id be detail	
eath. Page 6 may be retained by	rector, page 5 should be detached	
аде 6 тау	director, p.	
r death. F	he funeral	100
s wours after dea	ed in by th	or remov
within 25	pletely fille	remation
executed	n and com	to burial.
The law requires that the death certificate be executed within assets	the attending physician and completely filled in by the fur	liene prior
e death ce	he attendir	Mental Hvc
res that th	igned by t	leafth and
e law requi	has been s	Dept. of H
SICIAN: The	this certificate has bee	72 hours after death with the State Deot. of Health and Mental Hydiene prior to b
200	After this (death with
PITAL OR ATTENDI	IRECTOR: After this	Aurs after u
PITAL (RAL DI	72 hc

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIFI	TMENT OF HEAL CATE OF DE	JH AND ME	NTAL HYGIEN REG. NO.	E		
	1. DECEDENT'S NAME (First, Middle, Las	' 11 .				DATE OF DEATH DA		3. TIME OF OEATH	
	mary E	Herbert				12 11		194 5 30 A "	
	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR IF L		OATE OF BIRTH (Month, Day, Year)	0.	BIRTHPLACE (State or Foreign Country)	
	216–48–4536 90. FACILITY NAME (If not institution, give	1 🗆 M 2 💢 F	90 YRS.		M	arch 20, 1		Pennsylvania	
Œ	Golden Oaks Nur			9b. CITY, TOWN OR LO	CATION OF DEATH			Y OF DEATH	
DIRECTOR	RESIDENCE OF DECEDENT	sing home					Princ	ce George Co.	
) Ä	10a. STATE 10b. COUN	ITY	10c. CITY	, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?	
		Anne Arundel	S	<u>evern</u>				1 TYES 2 NO	
PA I	10e. STREET AND NUMBER			10f. ZIP			10g. CITIZE	N OF WHAT COUNTRY?	
FUNERAL	1722 Richfiel.				1144			USA	
	1 Never Married 2 Married	12. WAS DECEDENT EVER II FORCES? 1 YES	2 X NO	if yes, specify	Cuban, Mexican, P	ORIGIN? (Specify Yes uerto Rican, etc.)	or No- 14	I. RACE — American Indian, Black, White, atc.	
B	3 ₩ Widowed 4 □ Divorced	IF YES, GIVE WAR OR D	ATES	1 YES 2	NO Specify:			Specify: Black	
COMPLETED	15. OECEDENT'S ED (Specify only highest gra	DUCATION de completed	16a. DECEDENT'S	JSUAL OCCUPATION ork done during most of a		16b. KINO OF BUS	INESS/INDUS		
<u> </u>	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)	vorking				
₹ P	Grade School		Do	mestic		Private	e Fa	milv	
1 S	17, FATNER'S NAME (First, Middle, Last)			18. (MOTNER'S NAME (First, Middle, Maiden	Sumame)		
B g	James Ragler 190. INFORMANT'S NAME (Type/Print)		I no technology		Hannah	Hodge			
1 1				ADDRESS (Street and Nu					
8	Edna Carey 200. METNOD OF DISPOSITION	204		incoln Dri	ve J	essup, Ma		d 20794 y or Town, Stata	
m cst	1 M Buriel 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State Carr	etery, crematory or oth	e Memorial	Davel	Dec			
ner	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	adowi idq	22. NAME AND AD	DRESS OF FACILIT	Must tox	timore	e County, MD al Homes, Inc	
examiner must be notified at once. TO BE COM	+ Hanlat	5	tto	12301 GWV	nns fal.	IS Parkwa	av.	al Homes, inc	
	23. PART I. Enter the diseases, or	complications that causes	the death Do a		e. Marv	land 212	216		
the medical	snock, or neart failure	b. List only one cause on e	ach line.	or enter the mode of	aying, such se	cardiac or reapi	etory srrest	Interval Between	
ŝ	IMMEDIATE CAUSE (Final disease or condition resulting in death)								
le li	resulting in death) s								
other traumatic event, TIFICATION	2 10 10		11992	nisula	0.00	, dut	lega	month,	
y, or other traumatic	Sequentially list conditiona, If any, leading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	:					
2 2	CAUSE (Disease or injury	c	16500	>					
	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	:					
CER 9		d							
CAL CE	PART II. Other significant condition	ons contributing to death b	ut not resulting in	the underlying cau	se given in Part	t I. 24s. WAS AN / PERFORE		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
shows any : MEDIC						1 TYES 2		COMPLETION OF CAUSE OF DEATH?	
MEDIC								1 UYES 2 10	
S Z									
red, or item 23 s PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		28. PLACE (F DEATH (Check o	nnly one)			
14S	1 YES 2 NO 27. MANNER OF DEATN	1 Inpatient 2 ER/Outp	atlent 3 DOA	4 Nursing Nome 5					
	1 Natural 5 Pending	(Month, Day, Year)	28b. TIME INJU	OF 28c. INJURY A WORK?		I. DESCRIBE NOW IN	JURY OCCUR	ÆD	
	2 Accident Investigation 3 Suicide & Could and by	28e. PLACE OF INJURY	- At home, farm, st			LOCATION (Street ar	nd Number or	Primi Doube Mismbar	
Z8 IS TED	4 Homicide 8 Could not be detarmined	building, etc. (Spec	ify)			City or Town, State)	TO TRUITOR OF T	nural rocks realized,	
MPLE	29a. CERTIFIER (Check only 1 CERTIFYING PHY	SICIAN: To the best of my knowl	edge, death occurred	I at the time, date and o	lace and due to the		and the state of		
COMPLETED		NER: On the besia of examination						ause(a) end manner se stated.	
	29b. SIGNATURE AND TITLE OF CERTIFI				LICENSE NUMBER			IGNED (Month, Day, Year)	
BE	1/1.	140		1 6	1427	67	15	110194	
TF	30. NAME AND ADDRESS OF PERSON W	HO COMPLETED CAUSE OF DE	ATN (ITEM 27) (Type, I	Print)	,			7. 1/	
	Charis	SIIK 10	17 0	MENT (ana	1421	le	170	
у	DEC1 6 1994	32 REGISTRAR'S GR	all	7					



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		1 - STATE STATE OF MARYLAND / DEPARTMENT OF CERTIFICATE OF		HYGIENE REG. NO.
		1. DECEDENT'S NAME (First, Middle, Last) HOWARD C. Hartsfield	2. DATE OF MONTH	
		4. SOCIAL SECURITY NUMBER 5. SEX 1. Sex 1.	IF UNDER 24 HRS. 7. DATE OF (Month, D	BIRTH 8. BIRTHPLACE (State of Foreign
2, 3 should	OR	90. FACILITY NAME (If not institution, give street and number) North west tosportal Center Balti	or Location of DEATH	1D. Balfimore County
-	DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCA Phila december 10c. CITY, TOWN OR LOCA 10c. CIT	TION 2/0/2/2	10d, INSIDE CITY LIMITS? 1 \[\subseteq \text{VES} 2 \subseteq NO
physician, bunal-transit permit. Pages	FUNERAL		M. 28P CODE	10g. CITIZEN OF WHAT COUNTRY?
	BY FUN	1 Never Married 2 Married FORCES? 1 YYES 2 NO If yea, a	CENDENT OF HISPANIC ORIGIN? (Specify Cuban, Maxican, Puerto Rice 2 1) NO Specify:	
or attend	COMPLETED	15. DECEOENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	ON 16b. KI	ND OF BUSINESS/INDUSTRY
by the hospital be detached fo at once.		17. FATHER'S NAME (Flyst, Middle, Last) Harts Cield	18- MOTHER'S NAME (First, Midd	The back of the contract of th
retained to should be should notified	TO BE	190. INFORMANT'S NAME (Typoprin) Millicent Hartsfield 430 W. 7	and Number or Rural Route Number,	City or Town, State, Zip Code)
e 6 may ector, pa must b	10 DE	20s. METHOD OF DISPOSITION 1 Disputal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	al Cem. 12/16	Arlington Virginia
- D		21. SIGNATURE OF FUNERAL SERVICE LIBERIDEE 22. NAME / 2.50	GWYNNS FULLS	otter Fugeral Homes, PKNy. Balto, MD. 2126
executed within, fours after n and completely filled in by the to burial, cremation, or removal matic event, the medical		23. PART i. Enter the diseases, or complications that caused the death. Do not enter the methods, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death)	ode of dying, such as cardied	C or respiratory arreat, Approximate Interval Between Onset and Death
ysicia prior trau	CERTIFICATION	Sequentisity list conditions, if sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	Dend	
0 0 0	CERTI	resulting in dasth) LAST		
that the led by the and any in	MEDICAL	PART II. Other significant conditions contributing to death but not resulting in the underlying		a. WAS AN AUTOPSY PERFORMED? VES 2 100 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
新 10 mm 2 mm 2 mm 2 mm 2 mm 2 mm 2 mm 2 m			ES NO	1 YES 2 NO
certificate to the State of New	PHYSICIAN:	EXAMMER? 1 DYES 2 NO HOSPITAL: 1 Inpetiant 2 ER/Outpetlant 3 DOA 4 Nursing Ho	ne 5 Residence 6 Other (S	pecify)
NG PHYSICAN: The that this conflicate he sallt with the State D marked, or Item	ву Рн	1 Netural 5 Panding (Month, Day, Year) INJURY W	JURY AT 28d. 0EŞCR ORK? YES 2 NO	IBE HOW INJURY OCCUREO
	ETED !	3 Suicide 8 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, atreet, factory, offi building, atc. (Specify)		ON (Street and Number or Rural Route Number, own, State)
SPITE TO SPI	COMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, det one) 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion,		
TO THE HOSP TO THE FLINE De filed within	O BE C	296. SIGNATURE AND TITLE OF CERTIFIER ALCOHOLOGY ROLL MARCHES STANIAL	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	\succeq	NO MANUE AND ADDRESS OF SUPPLIES HAVE COMPANY OF THE PROPERTY	7 7 7 7 7 7	- Antiti



	alt permit. Pages 1, 2, 3 should		
w hospital or attending physician.	detached for use as the burial-tran		ance.
UAN. The law requires that the death certificate be seecuted within 54 hours after death. Page 6 may be retained by the houpital or attending physician	s certificate has been signed by the attending physician and completely filted in by the funeral director, page 5 should be detacted too use as the burial-basest permit. Pages 1, 2, 3		d, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
pecuted within the hours after the	sand completely filled in by the f	to burtal, crimation, or removal.	matic event, the medical ex
res that the death certificate be	signed by the attending physician	The State Dept. of Health and Mental Hygene prior to burlar, crimation, or r	ws any injury, or other trau
DING PHYSICIAN: The law regul	After this certificate has been a	death with the State Dept. of h	Sqarked, or Item 23 show
TO THE HOSPITAL OR ATTEN	FUNERAL DIR	De filed within 72 hours uppr	IMPORTANT: If Ipm 28

arked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COM

296. SIGNATURE AND FITLE OF CERTIFIER

31. DATE ELE 4106. 1994

MALE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

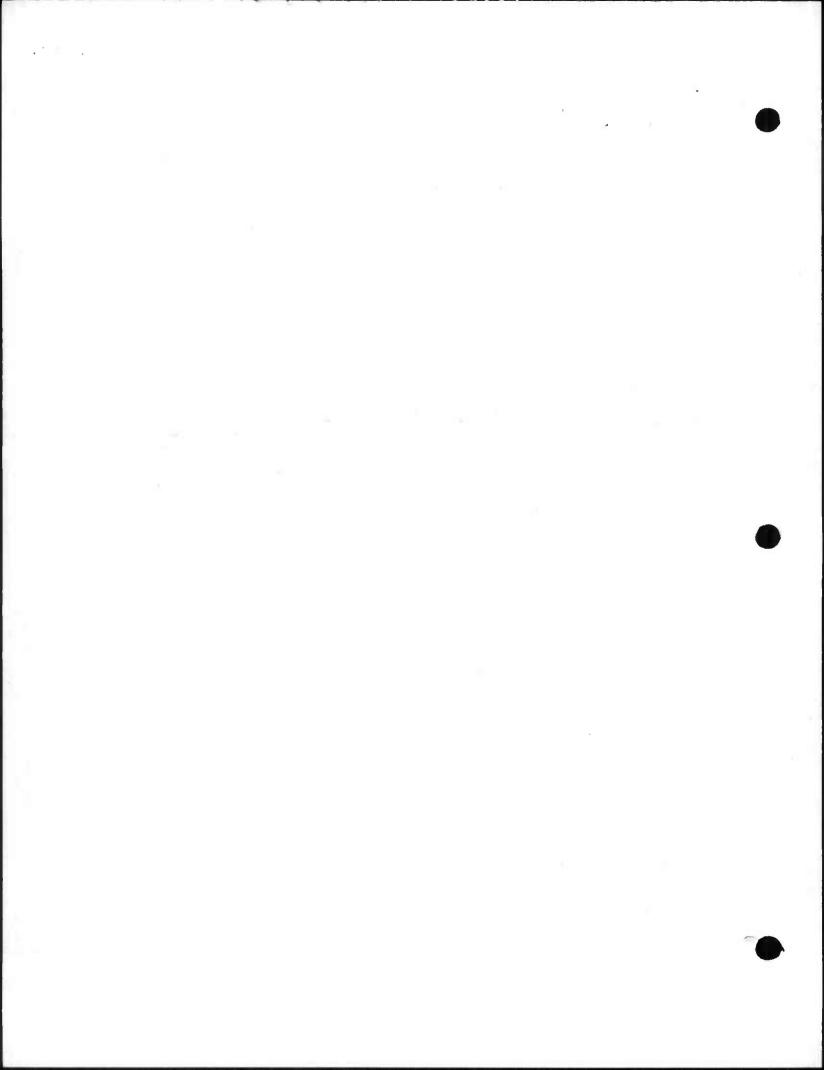
Julia District Mandali

							34	01,011.			
	1 - STATE REGISTRAR	STATE OF MARYLAN		TMENT OF I		MENTAL HYGIEN	_				
	1. DECEDENT'S NAME (First, Middle, ,Last)					2. DATE OF DEATH MONTH D	AY YEA	3. TIME OF DEATH			
		ilhemina	Hood			Dec. 15	1994				
			rrs. last birthday)	MONTHS DAYS	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	Co	RTHPLACE (State or Foreign puntry)			
	217 01 2213	□ M 2 🗓 F 8	l YRS.					Maryland			
œ	9e. FACILITY NAME (If not institution, give street				OR LOCATION OF DE		9c. COUNTY O				
5	Cherrywood Manor	Nursing Home		Re	isterstov	√n	Bal	timore			
3,50	10a. STATE 10b. COUNTY		10c. CITY	, TOWN OR LOCA	TION			10d. INSIDE CITY			
ā	Maryland Ba	ltimore		Rei	sterstown	n		LIMITS?			
A	10e. STREET AND NUMBER			10	I. ZIP CODE		10g. CITIZEN C	OF WHAT COUNTRY?			
ij.	29 Chestnut Hill				21136			U.S.A.			
BY FUNERAL DIRECTOR	11. MARITAL STATUS 1 Never Merried 2 Merried 3 X Widowed 4 Divorced	2. WAS DECEDENT EVER IN U. FORCES? 1 YES : IF YES, GIVE WAR OR DATE	2 NO	RMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yee, specify Cuben, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: Spec							
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade com	ION 18	Se. DECEDENT'S	USUAL OCCUPATI	ON	186. KIND OF BU	SINESS/INDUSTR	Υ			
Ħ		College (1-4 or 5+)	life. Do NOT us	rork done during mo e retired.)	ist or working						
MP	8th		H	lousewif	e						
8	17. FATHER'S NAME (First, Middle, Last)	77 1 1		18. MOTHER'S NAME (First, Middle, Maiden Surname)							
BE	Edward Kroll Charlotte Unknown 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number Of Burel Brute Number City of Texas State 7to Code)										
2	190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Charles Hood 29 Chestnut Hill Road Reisterstown, MD 21136										
	206. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of Date 20c. LOCATION — City or Town State										
	1 St Burlel 2 Cremation 3 Removal 4 Donation 5 Other (Specify)	from State cemete	ry, crematory or of	ark Cem	eterv			Maryland			
	21. SIGNATURE OF FUNERAL SERVICE LICENS		202110 2	22. NAME A	ND ADDRESS OF FAC	CILITY					
	► \ ///F					Funeral Di					
_	23. PART I. Enter the disesses, or com	nolications that caused the	ne death Do n					n, MD 21133			
	(shock, or heart failure. List IMMEDIATE CAUSE (Fine)	De vet	ilne.	ot enter the inc	de or dying, suci	n as cardiac or respi	ratory errest,	Approximats Interval Betwee Onset and Dec			
	resulting in death)		ONSEQUENCE OF				12211				
-		DUE TO (OR AS A CONSEQUENCE OF):									
Ö	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CO		D	<i>JC</i>						
ERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury										
E	that initiated events	DUE TO (OR AS A CO	ONSEQUENCE OF):							
ER	resulting in death) LAST										
PHYSICIAN: MEDICAL C	PART II. Other significent conditions co	ontributing to deeth but	not resulting in	n the underlyin	g ceuse given in	Pert I. 24a. WAS AN PERFOR	MED?	24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
ME								1 YES 2 NO			
ä	DID TOBACCO USE CONTRIB				UNCERTAIN	<u>۱ 🗆 </u>					
0		OSPITAL:		OTHER							
1×S	1 YES 2 HO 1	Inpetient 2 ER/Outpetie		4 Nursing Hom	e 5 🗌 Residence						
B/ PH	1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Yeer)	286. TIME	M 1 🗆	PRK? YES 2 NO	28d. DESCRIBE HOW II	NJURY OCCURED				
1	3 Suicide 6 Could not be 4 Homicide determined	28e. PLACE OF INJURY — building, etc. (Specify)	At home, term, at	treet, factory, offic		28t. LOCATION (Street of City or Town, State)	and Number or Rui	ral Route Number,			
-	Check only 1 CERTIFYING PHYSICIAN	N: To the best of my knowledg	ge, death occurre	d at the time, date	end place, end due	to the cause(e) end man	nner se stated.				

29c. LICENSE NUMBER

027123

29d. DATE SIGNED (Month, Day, Year) 12/15



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	REGISTRAR 1. DECEDENT'S NAME (First, Middle, L	43)		CERTIF	ICALE	: OF	DEAT	н	2. DATE OF	EG. NO.	-	1.	TIME OF DEAT
	JANICE	HUNT							MONTH	DAY	à	YEAR J.	1030
	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yrs.	last birthday)	IF UNDER		IF UNDER		7. DATE OF E	METH	1	BIRTHPL	ACE (State or Fo.
	218-78-0508	1 🗆 M 2 📈 F	35	YRS.	MONTHS	DAYS	HOURS	MIN.	July	28,19	59	Mary	land
~	9a. FACILITY NAME (If not institution, (OR LOCATIO				9c. COUNT	Y OF DEAT	Ή
5	Church Home Hospital Baltimore City												
DIRECTOR	10a. STATE 10b. CO			10c. CIT	Y, TOWN O	R LOCAT	TION					10	d. INSIDE CITY
	Maryland	Baltimore City							LIMITS? YES 2				
3AL	100. STREET AND NUMBER	2 1 2				101	. ZIP CODE		224				T COUNTRY?
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ВУ	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WI	YES 2	ARMED	- 11	f yes, sp			IC ORIGIN? (S n, Puerto Ricar :		r No- 1	4. RACE — Black, W Specify:	American indi Thita, etc. White
LED	15. DECEDENT'S (Specify only highest	EDUCATION grade completed)	16a.	DECEOENT'S (Give kind of	USUAL OC	CUPATIO	ON ast of working	0	16b. KIN	O OF BUSIN	NESS/INDUS	STRY	
LETI	Elementary/Secondary (0-12)	College (1-4 or 5+)		Factory Worker					Assembly Line				
COMPL	10 17. FATHER'S NAME (First, Middle, Last			racto	ry Wo	orke	,			ibbon		ufact	urer
)					_	ER'S NAI	ME (First, Middl	e, Maiden St Spric	,		
BE	Vernon Hunt 190. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street a			Toute Number, (Code)	
5	Vernon Hunt								Avenu				MD 2
	20a. METHOD OF DISPOSITION % Burlal 2 Cremation 3	Removal from State		CE AND DATE		ITION (Na	ame of		DATE		TION — CI	ty of Town,	Stata
	4 Donetion 5 Other (Specify)		Mt.	Carme	1 Cen				/10/94	Bal	timo	re, M	laryla
	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	. 0	,	22. ! Lj	LILY	ADDRES	eile:	r, Inc	. Fun	eral	Home	es
	Lilly & Zeiler, Inc. Funeral Homes 1901 Eastern Avenue Baltimore, MD 21 23. PART I. Enter the diseases, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approx												
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	s. CENE DUE TO (b. SUY) DUE TO (c. SUY) DUE TO (d. NFE	OR AS A CONS	SEQUENCE OF	30 L H1: H1:	17,	4-T1		LIK				
C	PART II. Other algnificant cond									. WAS AN A	mpev	2,46, 344	ERE AUTOPSY F
CA	Varvum					Sonyin	a canae à	.vvii III		PERFORM	ED?	AV CC	AILABLE PRIOF
MEDIC	MANAMA		186						_ ''	_ YES 2 [_ NO		DEATH?
-52 iii													
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINERS	HOSPITAL:			OTHER		LACE OF DE	EATH (Chi	ock only one)				
PHYS	1 YES 2 NO	1) A inpatient 2 28a, OATE OF		3 DOA	4 🗆 Nurs	Ing Hom		sidenca	8 Other (Sp		IIIIW ASS	INF.C	
-	1 Natural 5 Pending 2 Accident Investigat	(Month, De	y, Ybar)	IN	JURY	1 🔲	YES 2 [NO NO	28d. DESCRI				n Mumba
ВУ Р	3 Sudolda		tc. (Specify)		or, tack	- THE			City or To	wn, State)	a reunnuer of	nulai MOUI	e rvuinoer,
ETEG BY	3 Suicide 8 Could no 4 Homicide detarmine	building, e	,										
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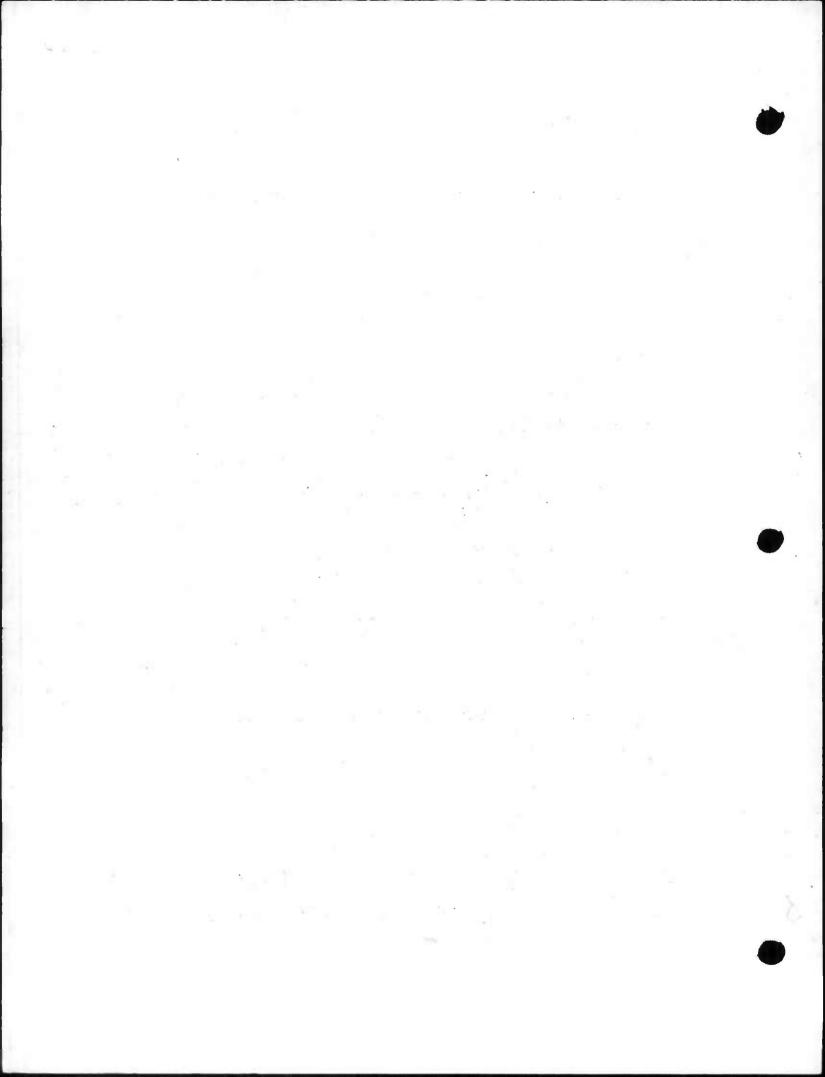
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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a new form of the form of the hospital or attending physician.	IRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	burs after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	sm 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSIC	TO THE FUNERAL DIRECTOR: After this of	be filed within 72 hours after death with t	IMPORTANT: If item 28 is marked,

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last) Betty L. Tolk	nson			2. DATE OF DEATH	8" 14°	3. TIME OF DEATH			
	4. SOCIAL SECURITY NUMBER 5	. SEX 6. AGE (In yrs. last birth	day) IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year		BIRTHPLACE (State or Foreign Country)			
E .	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH POLITY NAME (If not institution, give street and number)									
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY									
	MD Baltimore									
FUNERAL	100. STREET AND NUMBER 4004 Derby Mayor Dr 21215 109. CITIZEN OF WHA									
	1 Never Married 2 Married	2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES	If yea, sp		NIC ORIGIN? (Specify Yes or No.— 14. RACE — American Indian, In, Puarto Rican, etc.) Specify: Specify:					
ED BY	3 Widowed 4 Divorced 15. DECEDENT'S EDUCAT	ION 160 DECEDE	NT'S USUAL OCCUPATION			BUSINESS/INDUS	Black			
COMPLETE	(Specify only highest grade cor	npleted) (Give kin	d of work done during mo		166. KIND OF	BUSINESS/INDUS	TRY			
OME	17. FATHER'S NAME (First, Middle_Lest)		eticlo	16. MOTHER'S NA	ME (First, Middle, Maid	ien Sumame)				
BE C	Colel Bro	nenc		Less	ie So	2904	-5			
5	194. INFORMANT'S NAME (Type/Print)	19b, MAI	LING ADDRESS (Street of	and Number or Rural F	Route Number, City or	Town, State, Zip Co	L 40 7175			
	20a, METHOD OF DISPOSITION 1 % Burlel 2 Cremetion 3 Remove	20b. PLACE AND D. cemetery, crematory	ATE OF DISPOSITION (Ne	ame of	DATE / 20c.	LOCATION - CIT	or Town, State			
	4 Donation 5 Other (Specify)	Carrisa	a Formest	Veterans	99940	vims/	lills, MD			
	Lincola	C. Jan	WELL E	Derrich	to Aug	Balta	MD 21215			
	23. PART i. Enter the disease, or con ahock, or heart fellure. Lis	nplications that ceused the deeth. It only one cause of each line.	Do not enter the mo	de of dying, auci	ss cardiec or ra	plratory arrea	Approximate Interval Between			
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) Congestive Caudiony opathy Due to (or as a consequence of): Covanary Attery Disease									
z	Covanary Avery Disease									
RTIFICATION	Sequentially liet conditions, if eny, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEQUENCE	CE OF):							
IFIC.	CAUSE (Disease or Injury that initiated evente	DUE TO (OR AS A CONSEQUENC	CE OF):							
CERI	resulting In death) LAST									
A	PART II. Other algnificent conditions of		ing in the underlyin	g ceuse given in		AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO			
EDIC	Aypertensio	~			1 □ YES	2 NO	COMPLETION OF CAUSE DF DEATH?			
Σ	DID TOBACCO USE CO	NTRIBUTE TO CAUSE	OF DEATH Y	ES NO			1 YES 2 NO			
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	OSPITAL: Inpatient 2 ER/Outpatient 3 DO	28. PI	ACE OF DEATH (Che						
PHYS	1 YES 2 NO 1 27. MANNER OF DEATH	28a. DATE OF INJURY 28b.	. TIME OF 28c. INJ	e 5 Residence	6 Other (Specify) 28d. DESCRIBE HO	W INJURY OCCUR	ED			
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	M 1 🗆 '	res 2 🗌 NO						
8	3 Suicide 6 Could not be determined	28a. PLACE OF INJURY — At home, ta building, atc. (Specify)	irm, street, factory, offic	•	281. LOCATION (Stre City or Town, Sti	et and Number or (Rural Route Number,			
COMPLET		N: To the best of my knowledge, death oc On the bests of examination and/or investi					nuss(s) and manner as stated			
ш	296. SIGNATURE AND TITLE OF CERTIFIER	Λ		29c. LICENSE NUM	IBER	29d DATE SI	GNED (Month Day Year)			
TO B	30. NAME AND ADDRESS OF PERSON WHO C	uh THE M.D.		D413	65	1 De	29,1994			
	George E. 1	Wicks III 1	M,D, 26	600 Li	65 berty	Heigh	ts			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S CHATCHE	•		7					



TO BE COMPLETED BY FUNERAL DIRECTOR

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

STATE OF MARYLAND / DE	PARTMENT OF	HEALTH AND	MENTAL	HYGIENE
CERT	CIFICATE OF	F DEATH		BEG NO

1 - STATE REGISTRAR	STATE OF MARYLAN	D / DEPARTMENT CERTIFICATE			GIENE 3. NO.				
1. DECEDENT'S NAME (First, Middle, Last)	BASIL JONES, JR. 12 1								
4. SOCIAL SECURITY NUMBER 2/2-32-35/12	44	3. last birthday) if UNDER to MONTHS MONTHS	YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIR (Month, Day,	TH 8.	BIRTHPLACE (State or Foreign Country)			
96. FACILITY NAME (If not institution, give stress of the TEXTEST OF THE PRESIDENCE OF DECEMENT	int and number)	9b. CITY,	TOWN OR LOCATION OF D	EATH	9c. COUNTY	OF DEATH			
10a. STATE 10b. COUNTY	A.A.Co	10c. CITY, TOWN OF	LOCATION			10d. INSIDE CITY LIMITS? 1 YES 2 NO			
100. STREET AND NUMBER 7635 043 7	ELEGRAPH	21	101. ZIP CODE 2//4	4	10g. CITIZEI	L.S.A.			
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS OCCEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	NO If	AS DECENDENT OF HISPA yes, specify Cuben, Maxic YES 2 NO Speci	en, Puerto Ricen, a	olfy Yas or No- 14	. RACE — American Indian, Black, White, atc. Specify: Black			
15. DECEDENT'S EDUC. (Specify only highest grade of	ATION 15: completed) College (1-4 or 5 +)	DECEDENT'S USUAL OCC (Give kind of work done du life, Do NOT use retired.)	CUPATION uring most of working	166. KIND	OF BUSINESS/INDUS				
17. FATHER'S NAME (First, Middle, Lest)		JANITA	18. MOTHER'S NA	JAN JAN Middle, I	Maiden Surname)	SERVICE			
190. INFORMANT'S NAME (Type/Print)	3 S.L.	19b. MAILING ADDRESS	Juli (Street and Number or Fund	House Reumber City	ONES	rde) , / ,			
MARIE E JO. 200, METHOD OF DISPOSITION	NES	7635 OL	STELEGR	opt Ra	SEVER	N Ud. 21144			
Buriel 2 Cremetton 3 Remort 4 Donation 5 Other (Specify)	val from State cemeter	crematons or other place)	VEN HEN	12-16	GLAN B	URNE, Ud.			
M. Signature of Johnson, Service Sch	Koulu	22. N	AME AND ADDRESS OF FI 1206 W	BROWN	LAVE	WITH FIH			
23. PART I. Enfer the diseases, or conshock, or heert failure. L iMMEDIATE CAUSE (Finel disease or condition resulting in death)	omplications that caused the list only one ceuse on each	U Care	he mode of dying, such	ly u	respiratory arrest	Approximate Intervsi Between Onset and Death			
Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CO			/					
CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CO	NSEQUENCE OF):							
PART ii. Other significant conditions	contributing to death but r	not resulting in the und	lerlying cause given in	P	WAS AN AUTOPSY ERFORMED? YES 2 NO	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE			
DID TORACCO LISE CONTR	IDLITE TO CALLEE OF	NEATH VEC 17 A		_	TES Z NO	OF DEATH?			
DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26.	PLACE OF DEATH (Check or	nly one)	NLI					
1 TES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient		ng Home 5 - Rasidence	8 Cher (Speci	fy)				
27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28s. DATE OF INJURY (Month, Day, Year)	28b, TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE	HOW INJURY OCCUR	ED			
3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — I building, atc. (Specify)	At home, ferm, street, fector	ry, offica	28f. LOCATION (City or Town	Street and Number or , State)	Rural Route Number,			
	IAN: To the beat of my knowledg					ause(s) and manner as stated.			
296. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NU	MBER		IGNED (Month, Day, Year)			
30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF OEATH	(ITEM 27) (Type, Print)	DSS	2110	12	-15-94			
MARC A. VADION 31. DATE FILED (Month, Day, Yeld)	7845 OAKU	100d RD#30	o Glen Bu	RDIR 1	no 210	101			
17 15 QU DECT	32. REGISTRAR'S SIGNATUR	antrockadall							

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DIVISION OF VITAL RECORDS. P.O. BOX 68760.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAN		CERTIF	ICATE U	PUEAIH	REG. NO.		
		1. DECEDENT'S NAME (First, Middle, Last) Shirley E. Vo	rdan				2. DATE OF DEATH DO 12 12	94	3. TIME OF DEATH
		010 51 00		(in yrs. last birthday)	IF UNDER 1 YEAR		7. DATE OF BIRTH (Morth, Day, Year)	C.	IRTHPLACE (State or Foreign puntry)
2, 3 should	e e	9a. FACILITY NAME (If not institution, give street Sinai Hospital	t and number)			O, MD		BALT	
£.	5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		1 10 41					
nit. Page	DIRECTOR	Md			3a H	CATION			10d. INSIDE CITY LIMITS? 1 YES 2 NO
physician. burial-transit permit. Pages 1,	FUNERAL	100. STREET AND NUMBER 4242 Binne	r Road	1		101. ZIP CODE		10g. CITIZEN C	OF WHAT COUNTRY?
	BY	11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced	PORCES? 1 YES IF YES, GIVE WAR OR DA	2 X NO	If yea,	ECENDENT OF HISPAI specify Cuben, Mexica ES 2 NO Specif			ACE - American Indian, Black, White, etc.
attending se as the	G	15. DECEDENT'S EDUCAT	ION	18a. DECEDENT'S	USUAL OCCUPA	TION	16b. KIND OF BUS	SINESS/INDUSTF	Y
al or for u	COMPLET	(Specify only highest grade con Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	/	Relping	Hospi	tal +	Facility
be det	BE CO	17. FATHER'S NAME (First, Middle, Last) Demand Joh	rdan Sr			16. MOTHER'S NA	ME (First, Middle, Maiden	Surname) Mack	
be retained to ge 5 should e notified	TO B	19a, INFORMANT'S NAME (Type/Print) Sarah Jardan		196. MAILING	ADDRESS (Street	et and Number or Rural.	Route Number, City or Town	n, State, Zip Code,	nd ZIZIS
e 6 may rector, pa		20 F. METNOD OF OISPOSITION 1 Serial 2 Cremation 3 Removal 4 Donation 5 Other (Specify)		PLACE AND DATE OF OFFICE OF OFFICE OF OFFICE OF OFFICE OFFI	ther place / /	wich Cen	12/17/94 Re	CATION - City o	r Town, State
. Page ral dire		21. SIGNATURE OF FUNERAL SERVICE LICEN	safe O d	1	22. NAME	AND ADDRESS OF FA	CILITY	7 - 7 - 7 - 7)
rs after death. Pag n by the funeral di removal.		· Anla	Marc	h	Mar	43.00 l	Wabash.	Ave E	30Ho Md 21215
with operation of cremation, or ent, the m		23. PART-I. Enter the dieeesea, or com- ahock, or haert feliure. Lief IMMEDIATE CAUSE (Finel diseese or condition resulting in death)	Metastati	ech ilne.	ast C	ance of dying, auc	h as cardiec or reapi	refory arreat,	Approximate interval Between Onset and Daath
and o bur	CATION	Sequentially list conditions, if any, laading to immediate	DUE TO (OR AS A	CONSEQUENCE OF	· · · · · · · · · · · · · · · · · · ·				
ficate be physician ne prior t	ICAT	ceuse. Enter UNDERLYING CAUSE (Disease or injury							
th certification in Hygie or other	CERTIFIC	that initiated evente resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF	7):				
the dead the all Ments		PART II. Other significent conditions of	ontributing to deeth b	ut not regulting i	n the underly	ing ceuse given in	Part I. 24s, WAS AN	ALITOPSY	24b. WERE AUTOPSY FINDINGS
# 2 2 3	EDICAL				/ =/// = = == /		PERFOR	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
S ea c	MEC								DF DEATH? 1 YES 2 NO
has been Dept. of h	z	DID TOBACCO USE CONTRIB	UTE TO CAUSE O	F DEATH YE	S 🗆 NO	☐ UNCERTAI	N D		
N: The licate has State D	PHYSICIAN:		OSPITAL:	26. PLACE OF DEAT	N (Check only on OTHER:	ne)			
SICIAN: The certificate the State	175	1 YES 2 NO 1	□ Inpetiant 2 □ ER/Outp. 28a. DATE OF INJURY	atlant 3 DOA 28b. TIM		ome 5 Rasidence		I I I I I I I I I I I I I I I I I I I	
PHY this with	BY PI	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJ	M 1	WORK? YES 2 NO	28d. DESCRIBE HOW II		
OR ATTENDING DIRECTOR: After hours after death	ETED	3 Suicide 6 Could not be 4 Nomicide detarmined	28a. PLACE OF INJURY building, etc. (Spec	— At homa, ferm, a	itreet, factory, of	fice	281. LOCATION (Street a City or Town, Stete)	nd Number or Rui	rel Route Number,
보 = 12 m	APLET	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN ONE)							
HOSPITAL FUNERAL WITHIN 72	COM	2 MEDICAL EXAMINER: 0	n the basis of axamination	and/or Investigation	n, in my opinion.	, death occured at the	time, data and place, and	I due to the caus	se(s) and mannar as stated.
TO THE HOSPITAL TO THE FUNERAL be filed within 72 ? IMPORTANT: If I	TO BE	29b. SIGNATURE AND THE OF CERTIFIER		on =		29c. LICENSE NUR 04217	ABER 7	29d. DATE SIGN ► (2)	ED (Mapth, Day, Year)
	-	30. NAME AND ADDRESS OF PERSON WHO CO	an no	2435 L	0	luedire 5	He. 23 B	alto,	MD 21215
		31. DATE FILED (MONTO) Co. 6 199.	32. REGISTRAR SISIGNA	HOT RONAL	4				



. BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

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after death. Page 6 may be retained by the hospital or atte	he fu	tion, or removal.	AYS
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ENDI	R: At	er de	8
AT	ECTO	rs aft	1 28
AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 📻 nours after death, Page 6 may be retained b	L DIR	be filed within 72 hours after death with the State Dept., of Health and Menta	IMPORTANT if item 28 is marked or item 23 shows any injury or other trainaite event the medical evaminar must be noti-
SPITA	VERA.	31 UE	II. II
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DEC 171994

	Item # 1,17 film #	G 718 12-19-94 N.	A. Per	funeral	nome			94	37322
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND		TMENT OF			YGIENE EG. NO.		
	1. DECEDENT'S NAME, Geneview	HEVE T	CEH	NLE		2. DATE OF D	EATH DAY	199	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 213-32-7624 90. FACILITY NAME (If not institution, give sti	5. SEX 1 M 2 X F 102	lest birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		er 14	1892	BIRTHPLACE (State or Foreign Country) Maryland
TOR	Northwest Hospit	,			allstown	EATH		Bal1	of DEATH Limore
FUNERAL DIRECTOR	100. STATE 10b. COUNTY Maryland Cari		10c. CITY	Marr:	TION iottsvile	21			10d. INSIDE CITY LIMITS? 1 YES 2 NO
	100. STREET AND NUMBER 7043 Marriotts	ville Road	•	10	M. ZIP COOE 21104	ı		U.S.	OF WHAT COUNTRY?
B≺	11. MARITAL STATUS 1 Never Merried 2 Merried 3 🖔 Widowed 4 Divorced	12. WAS DECEOENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES		If yee, a	CENDENT OF HISPAN Decify Cuban, Mexice S 2 NO Specify	n, Puerto Ricen,	ecify Yes o	r No — 14.	RACE — American Indian, Black, White, etc. Specify: White
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of w life. Do NOT us	usual occupation done during me retired.) emaker		16b. KIND	OF BUSIN	Domes	
BE CO	17. FATHER'S NAME (First, Middle, Last) Mary A. Col	ltart Patric	k Hepb	urn	18. MOTHER'S NA	ME (First, Middle,		M	ary A. Coltart
10	196. INFORMANT'S NAME (Type/Print) Mr. Francis Charles Pressimone 19b. MAILING ACCRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3706 Mactavish Avenue Baltimore, MD 212								
	20e, METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remo 4 Donation 5 Other (Specify)	val from State cematary. West	ACE AND DATE of DISPOSITION (Name of y. cramatory or other place) tern Cemetery Dec. 16, 1994 Baltimore, Md.						
	21. SIGNATURE OF FUNERAL SERVICE LICE	Haight	5	P.0.1	Box 195 S	Haight Sykesvi	11e,	Md. 2	21784
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, above, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF):								
ERTIFICATION	Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa reaulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								
MEDICAL CE	PART II. Other algnificant conditions	a contributing to death but no	t reaulting l	n the underlyin	g cause given in		WAS AN AU PERFORM YES 2	EO?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONTR			S NO D		N 🗆			1 □ YES 2 □-NO
PHYSICIAN:	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	HOSPITAL: 1. inpetient 2 ER/Outpetient 28e. DATE OF INJURY		OTHER: 4 - Nursing Hor	ne 5 Reeldence	8 Other (Spe		URY OCCUR	FO
ВУ	1	(Month, Day, Yeer) 28e. PLACE OF INJURY — At building, etc. (Specify)	INJU	M 1	ORK? YES 2 NO		(Street and		Rural Route Number.
COMPLETED	and .	CIAN: To the beet of my knowledge,							suse(a) and manner so wated
TO BE CO	296. SIGNATURE AND TITLE OF CERTIFIER	low.		. ,,	29c. LICENSE NUN				GNED (Month, Day, Year)

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 35 hours after death. Page 6 may be retained by the hospital or attending physician.

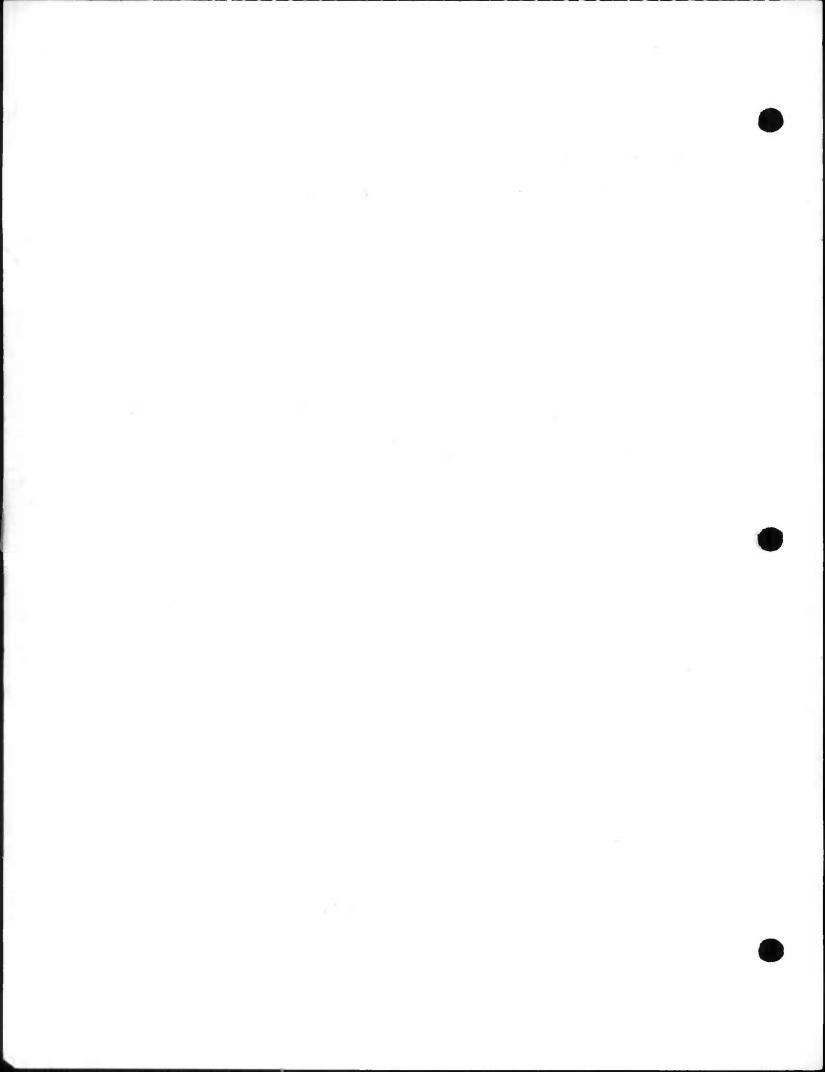
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE OF MARYLAND	/ DEPARTM			MENTAL HYGI						
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATI	н	3. TIME OF DEATH				
	Joseph Henry Kramer, Jr. Dec. 16, 1994										
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs.	lest birthday) IF L	NDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		4 4:38 A M B. BIRTHPLACE (State or Foreign Country)				
	216-20-3554 ¹X™2□F 68	YRS. MON		HOURS MIN.	12/23/		Maryland				
œ	9s. FACILITY NAME (If not institution, give street and number)			R LOCATION OF D		2.0	Y OF DEATH				
FUNERAL DIRECTOR	Northwest Medical Center		Randa	11stow	n	Bal	timore				
RE	10a. STATE 10b. COUNTY	10c. CITY, TO	WN OR LOCAT	ION			10d. INSIDE CITY LIMITS?				
ā	Maryland Baltimore			ville			1 TES 2 NO				
RAL	10e. STREET AND NUMBER		101	ZIP CODE	000	10g. CITIZI	EN OF WHAT COUNTRY?				
N.	2525 Old Frederick Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S.	ADMED	42 480 000		228 NIC ORIGIN? (Specify	<u> </u>	USA				
	1 Never Married 2 Married FORCES? 1 XYES 2	NO	If yes, sp		en, Puerto Rican, etc.		4. RACE — American Indian, Black, White, etc.				
BY	3 Wildowed 4 Divorced WW II & Kor		1 1 123	2 M NO Specii		White					
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	(Give kind of work of	lone durina ma	N st of working	16b. KIND OF	BUSINESS/INDU	STRY				
Ę.	Elementary/Secondary (0-12) College (1-4 or 5+)	Polic			Torr	Enfor					
MC	17. FATHER'S NAME (First, Middle, Last)	F011C	e ori		ME (First, Middle, Ma		cement				
Ö	Joseph Henry Kramer,	Sr.					" Snair				
) BE	19e. INFORMANT'S NAME (Type/Print)		RESS (Street a		Route Number, City or						
2	Estella J. Kramer	2525 0	ld Fr	edericl	c Rd. Ca	atonsv:	ille, MD 21228				
	20a, METHOD OF DISPOSITION 1	CEAND DATE OF DIS	POSITION (Na	me of	100	TE 20c. LOCATION — City or Town, State					
	4 Donation 6 Other (Specify) Cre:	st Lawn				arriot	tsville, MD				
	MacNabb Funeral Home, P.A.										
4	George E. MacNabb		301 I	rederi	ck Rd.	Balto.	, MD 21228				
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heart failure. List only one cause on each line. Approximate interval Between										
- 1	IMMEDIATE CAUSE (Final disease or condition A CAUGE DATA DAY EMPORT TO A										
ŀ	resulting in death) a. ACUTE PULMONARY EMBOLISM Due to (or as a consequence of):										
z	DIARETIC NEUROPATHY AND NEPHROPATHY										
CERTIFICATION	if any, leading to immediata	DUE TO (OR AS A CONSEQUENCE OF):									
Ş.	cause, Entar UNDERLYING CAUSE (Disease or Injury										
Ë	that initiated events DUE TO (OR AS A CON- reaulting in death) LAST	SEQUENCE OF):									
E	d										
AL	PART II. Other aignificant conditions contributing to death but no	ot resulting in the	e underlying	causa given in	Part I. 24a. WAS PER	AN AUTOPSY	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
PHYSICIAN: MEDIC	VENTRICULAR TACHYCARDIA				1 YES	5 2 X NO	COMPLETION OF CAUSE OF DEATH?				
X	- DID TOPACCO LISE CONTRIBUTE TO CALISE OF DE	PATH NEC F	7 110 8	LINIGEDTAN			1 TYES 2 NO				
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE	ACE OF DEATH (C)		UNCERTAI	иЦ						
SICI	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Ninpetient 2 ER/Outpetient	ОТ	HER:	5 □ Sacidanas	8 Other (Specify)						
Ä	27. MANNER OF DEATH 28s. DATE OF INJURY	26b. TIME OF	26c. INJ	JRY AT	28d. DESCRIBE HO	W INJURY OCCU	RED				
ВУР	1 XX Netural 5 Pending (Month, Day, Year) 2 Accident Investigation	INJURY	M 1 🗆 1								
	3 Suicide 8 Could not be 28s. PLACE OF INJURY — At building, atc. (Specify)	home, farm, atreel,	factory, office		28f. LOCATION (Str. City or Town, St	eet and Number or	Rurel Route Number,				
	4 Homicide datarmined										
Solution to be datarmined building, etc. (Specify) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner as stated.											
								BE (29b. SIGNATURE AND TITLE OF CERTIFIED	MD-	
0	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (I		·	D271	57	12	/16/94				
	· ·		nnic	lone T	Tood 1	MD	21244				
11	Raynold DePestre, M.D. 23100 Timanus Lane Woodlawn, MD 21244										
	31. DATE-FILED (April 600 994 Julio 22) ARABY MAY'S SIGNATURE			Julie .	·oodiawi	, 110	21277				

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Oept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760

	ITEM: 23 PART I, 27,	PER MEO F	ILM G-719	1/9/9	5 t.t.				1	4	, 102.	
	1 - STATE REGISTRAR	STATE OF N				HEALTH AND			E			
	1. DECEDENT'S NAME (First, Middle, Last)			MILIE	ICATE C	PEAIN	2. DATE OF D				3. TIME OF DEATH	
	DONALD KNOX						DEC	06	9	4 YEAR	5:43P M	
	4. SOCIAL SECURITY NUMBER 218 - 64 - 6364	5. SEX	6. AGE (In yrs. les		IF UNDER 1 YEA		7. DATE OF BI (Month, Day, May 14	Year)	55	Country	PLACE (State or Foreign	
	9e. FACILITY NAME (If not institution, give str	- 41	- 10		9b. CITY, TOV	/N OR LOCATION OF E		2,13.		NTY OF DE		
OR	kimbrough hosp:	ital			FORT	MEADE			ANN	IE AI	RUNDEL	
DIRECTOR	10e. STATE 10b. COUNTY			10c. CIT	Y, TOWN OR LO	CATION					10d. INSIDE CITY	
	Maryland Howard	1									LIMITS? 1 YES 2 NO	
FUNERAL	Jessup Correction	al Facil	tv			10f. ZIP CODE			USA		HAT COUNTRY?	
SNE	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. ARI		13, WAS	DECENDENT OF HISPA	NIC ORIGIN? (So	ecify Yes		14 BACE	- American Indian.	
B√	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 IF YES, GIVE W	YES 2 XN	10	If yes	, specify Cuben, Mexic YES 2 NO Speci	en, Puerto Ricen,			Black,	, white, etc. Black	
윤	15. DECEDENT'S EDUC (Specify only highest grade of		(G/	ve kind of v	USUAL OCCUP	ATION most of working	16b. KIND	OF BUS	INESS/IND	DUSTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5 a	.)	Do NOT us			Unkn	nown				
COM	17. FATHER'S NAME (First, Middle, Last)	KIII NAII					AME (First, Middle,	, Maiden S	Sumeme)			
BE	Eslie Knox 190, INFORMANT'S NAME (Type/Print)					Cather						
2	Jerome O. Briggs					ngton St.						
	20e. METHOD OF DISPOSITION	and from State	20b. PLACE A	NDDATE	OF DISPOSITION		DATE 20c. LOCATION — City or Town, State				vn, State	
	1 Buriel 2 Cremetion 3 Remo		Cemetery, cree	matory or or			12/10 Baltimore, Maryland					
	22. NAME AND ADDRESS OF FACILITY Nuttrer Funeral Home II 2501 Gwynn Falls Parkway Balt. Md. 21216											
_	Comes of	18m	y.W.			_	_					
	23. PART t. Enter the diseases, or complications there are detected to death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. UNDETERMINED											
NO	DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):											
CERTIFICATION	If eny, leading to immediate cause. Enter UNDERLYING											
Ĭ.	CAUSE (Disease or injury that initiated evente DUE TO (OR AS A CONSEQUENCE OF):											
SER	resulting in death) LAST			_							-	
PHYSICIAN: MEDICAL	PART ii. Other significent conditions	contributing to	deeth but not re	sulting i	in the underl	ying ceuse given in		WAS AN A PERFORI	MED?		WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE	
MED								CES 2	_ NO		OF DEATH? 1 DeyES 2 □ NO	
N.	DID TOBACCO USE CONTR	IBUTE TO CA					N 🗆					
<u>S</u>		HOSPITAL:			OTHER:							
HYS	27. MANNER OF DEATH	1 Inpatient X X	INJURY	28b. TIM	E OF 28c.	INJURY AT	8 Other (Spe- 28d. DESCRIBI		JURY OCC	CURED		
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month, D	sy, 16ar)	INJ	M 1	WORK? YES 2 NO						
	3 Suicide 8 Could not be 4 Homicide datermined	28e. PLACE Of building,	F INJURY — At horetc. (Specify)	ne, farm, s	street, factory, o	ffice	28f. LOCATION City or Tow		nd Number	or Rural Ro	oute Number,	
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC XX MEDICAL EXAMINER					late end place, end du					end menner es stated.	
BE	29b. SIGNATURE AND TITLE OF GERTIFIER	990	1			29c. LICENSE NU			29d. DATE	EC.	(Month, Day, Year) 07/94	
٩	30. NAME AND ADDRESS OF PERSON WHO					, Balti	more,	Mar	ylar	nd 2	1201	
DEC16 1994 July Director Marches March												



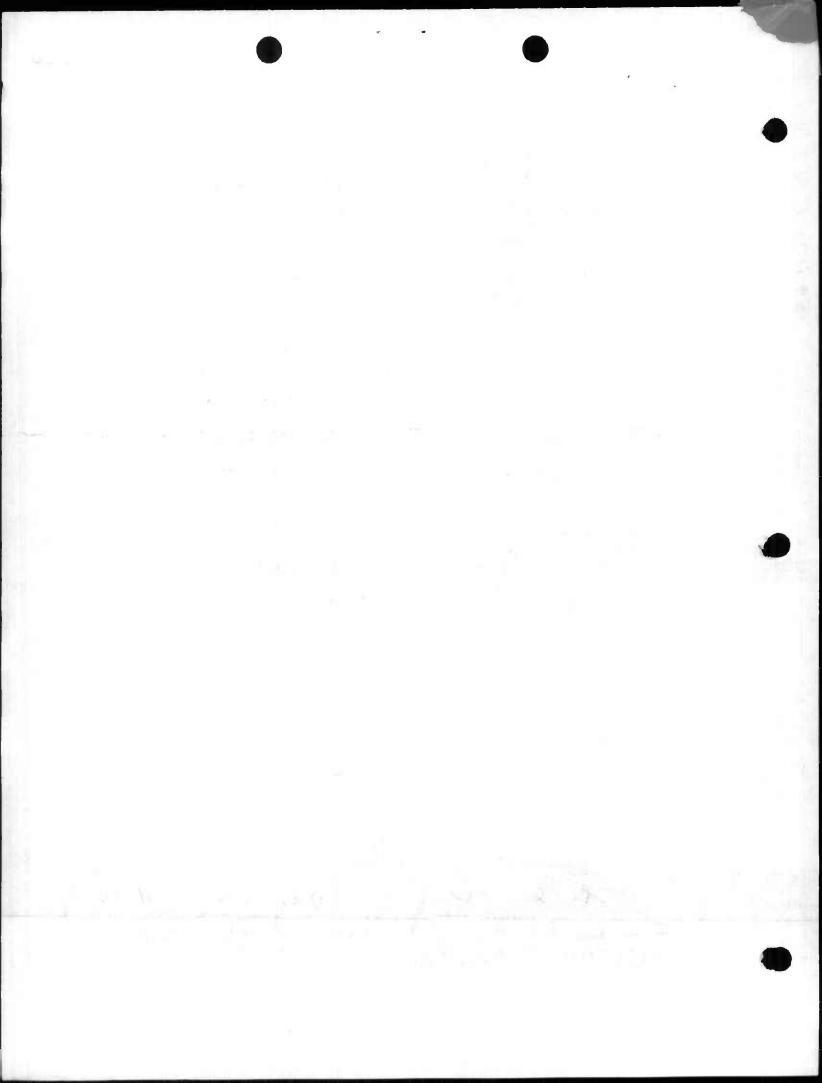
S, P.O. BOX 68760,
RECORD
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DIVISION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a medical branch Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

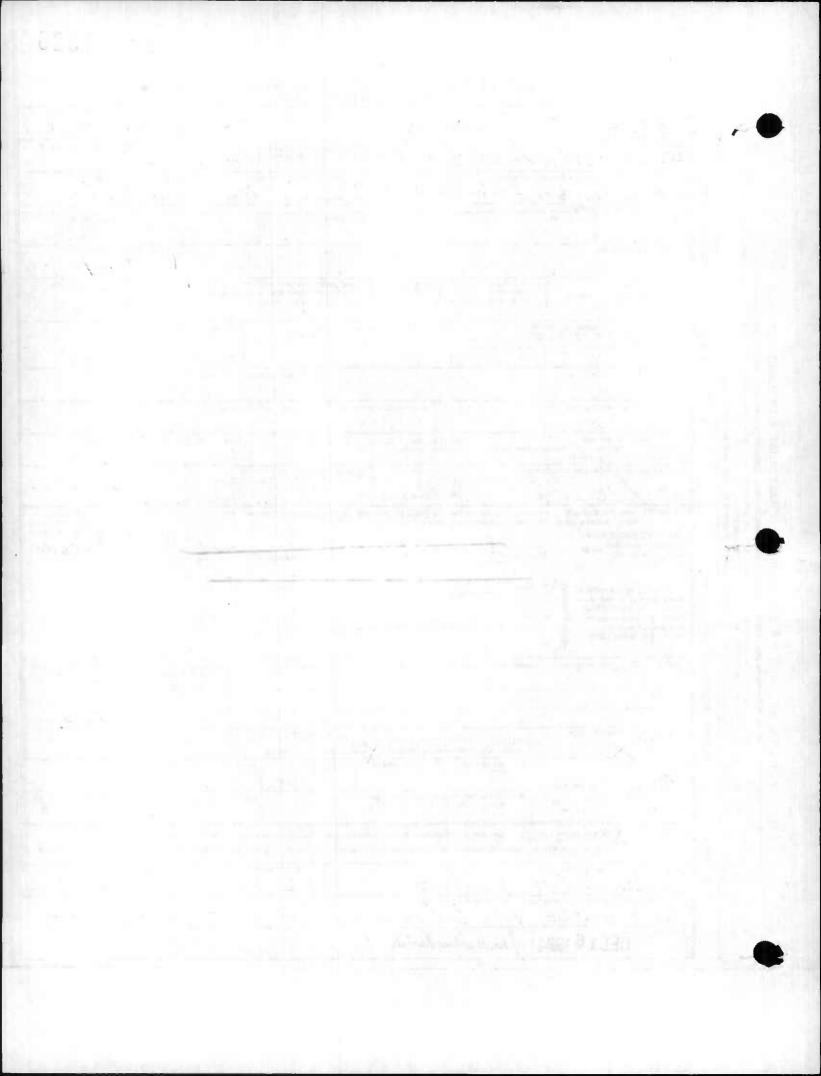
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAR	RTMENT (OF HEA	LTH AND	MEN1		_			
	1. DECEDENT'S NAME (First, Middle, L	usle lale			IOATE	OI DI	LAIN	2. DA		AY Q	YEAR	3. TIME OF OE	АТН
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDER 1		UNDER 24 HRS	- 414	TE OF BIRTH		8. BIRTH	PLACE (State or	Foreign
		1 (M 2 F		YRS.	MONTHS	AYS HO	URS MIN.		/01/94		Ma r	vland	
œ	9a. FACILITY NAME (If not institution, g						CATION OF	DEATH		9c. COUN	TY OF DE		
210	Prince George	s Hospital	Center		Cheve	rly_				Prin	ce G	eorges	
DIRECTOR		nce George	es	Bla	y, town on adensb	urg						10d. INSIDE CIT LIMITS? 1 X YES 2	
3AL	10e. STREET AND NUMBER	- "				10f. ZIP	CODE			10g. CITI	ZEN OF W	HAT COUNTRY?	
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밀	15. DECEDENT'S (Specify only highest g	EDUCATION raide completed)	18a. DE	CEDENT'S	USUAL OCCI	JPATION	working	1	6b. KIND OF BUS	SINESS/IND	USTRY		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5		Do NOT us	ne retired.)				nor	ie .			
BE CO	17. FATHER'S NAME (First, Middle, Last)					18.	MOTHER'S I		t, Middle, Maiden JEE	Surname)			
10	19a. INFORMANT'S NAME (Type/Print) Mother		191	5/22	ADDRESS (S	treet and No	mber or Run	Il Aoute Nu	imber, City or Town	n, State, Zip	Code)		
	20e. METHOO OF DISPOSITION		200 01 405						Blader	-			207
	20b. PLACE AND DATE OF DISPOSITION OATE 1												
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY												
rion	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and a cardiac or												
CERTIFICATION	If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST OUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF):												
PHYSICIAN: MEDICAL	PART II. Other significant condit	lona contributing to	death but not re	eaulting i	n the under	rlying cau	se given i	n Part I.	24a, WAS AN PERFOR	MED?		WERE AUTOPSY I AMAILABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2	CAUSE
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S S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL			OTHER:	8. PLACE	OF DEATH (C	heck only	one)				
17S	1 VES 2 XHO 27. MANNER OF DEATH	timpatient 2			4 - Nursing			7					
	1 X Natural 5 Pending	28a. OATE OF (Month, Da		26b. TIME INJ	URY	WORK?		28d. O	EŞCRIBE HOW IN	JURY OCC	JRED		
) BY	2 Accident Investigation M 1 YES 2 NO								CATION (Street a	nd Number o	or Privat Do	uta Mumber	
E	4 Homicide determined		etc. (Specify)					Cit	y or Town, State)	no morning	A THUMBIT FROM	ore recinoes,	
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYING PH 2 MEDICAL EXAM	YSICIAN: To the best of iNER: On the basic of ex	my knowledge, des emination end/or in	ith occurre	d at the time,	data and p	lace, and du	e time, de	ause(a) and man	ner se state	d. cause(e)	and menner se :	stated.
BE C	296. SIGNATURE AND TITLE OF CERTIF		10				LICENSE NU				_	Yorth, Day, Year)	
2	30. NAME AND AGORESS OF PERSON	WHO COMPLETED CALLS	F OF DEATH STORY	27) /5	Defeat)		34	22	9	• 9	10/	94	
	Zeva da t 31. DATE FILED (Month, Day, Year)	P. Alido	n PI		e Ge	erc	cs be	Spr	tel	Car	ya		
	DEC1 7 1994	32 REGISTRAL	s signature			0		0					



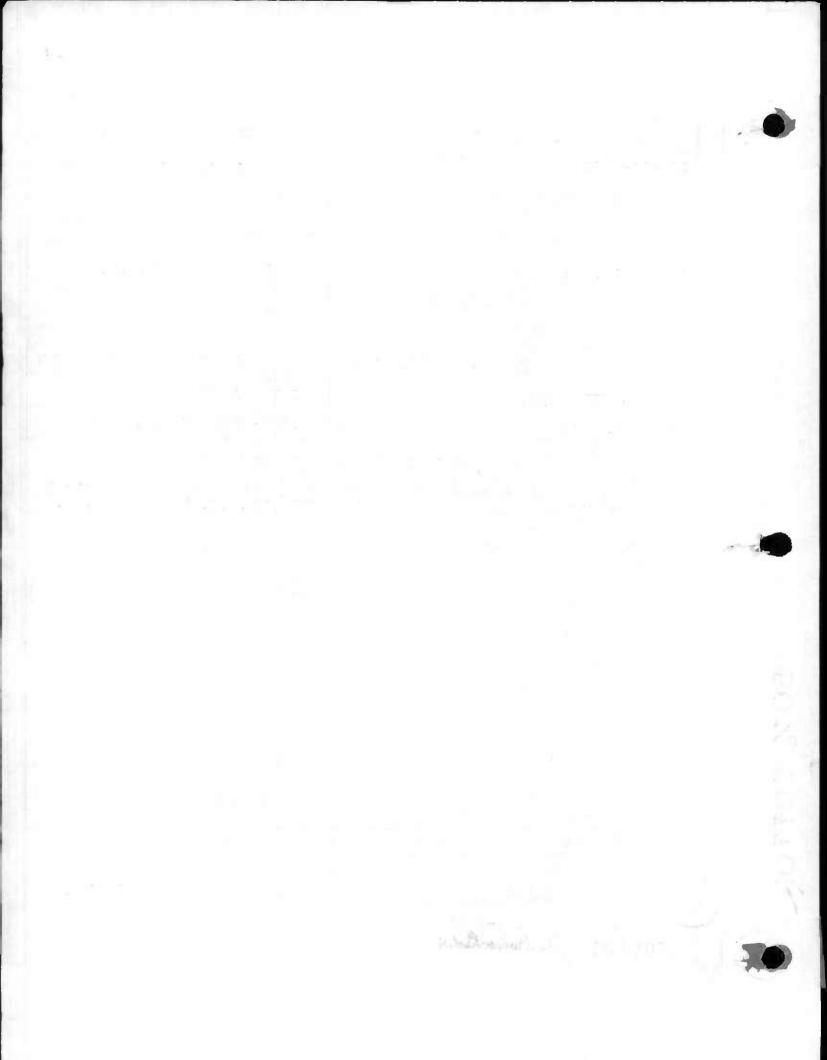
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(US, P.O. B	the death certificate	y the attending physic
JRDS, P.O. BOX 68/60,	that the death certificate be executed within. Sours after death. Page 6 may be retained by the hospital or atte	ed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use a

	1. DECEDENT'S NAME (First, Middle, Last		RSON.			2. DATE	OF DEATH	1- 5	S. TIME OF DEA
	4. SOCIAL SECURITY NUMBER 4.2.7.2.4.8.7.5	5. SEX 8. AGI	E (In yrs. last birthday)	F UNDER 1 YE	AR FUNDER 24 HRS.	7. DATE (Mont	OF BIRTH h, Day, Year)		BIRTHPLACE (State or F Country)
	9e. FACILITY NAME (If not institution, give) / Inc.	96, CITY, TO	WN OR LOCATION OF	DEATH	7-15	9c. COUNTY	Minnesota OF DEATH
DIRECTOR	LORIEN NUTSI		nortedulic	/	umbia	MI	> -	Her	und.
REC	10a. STATE 10b. COUN	TY	10c. CIT	TY, TOWN OR L	DCATION				10d. INSIDE CIT
	Minn.		Ev	eleth					1 TYES 2 1
FUNERAL	514 Jackson St.				101. ZIP CODE 5.	5734		10g. CITIZEN	USA
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 YES	S 2 NO	if yo	DECENDENT OF HISP s, specify Cuben, Mexic YES 2 NO Specific	can, Puerto		or No 14.	. RACE — American Ind Black, White, etc. Specify: Whit
COMPLETED	15. DECEDENT'S ED (Specify only highest grad		16a. DECEDENT'S (Give kind of	work done durin	PATION g most of working	168	. KIND OF BUS	MESS/MOUS	TRY
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MP	17. FATHER'S NAME (First, Middle, Lest)	Δ+	Teacl	her	18. MOTHER'S N				1 System
EC	Fred Larson								
00	190. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (St	reet and Number or Rurs		Johanns		ide)
2	Susan L. Larso	on			am Rd., E				
	20a, METHOD OF DISPOSITION 1 ☑ Burlai 2 ☐ Cremation 3 ☐ Re	2	Ob. PLACE AND DATE	OF DISPOSITIO		OAT	E 20c. LOC		y or Town, Stata
	4 Donation 5 Other (Specify)		Forest H:		metery	12/	18 And	oka, M	inn.
	21. SIGNATURE OF FUNERAL SERVICE L	4	meson	Gar	y L. Kaufr 5 <u>Main St</u>	man F			of Elk., I 21227
		DUE TO COR AS	A COMPEQUENCE O	D. D.D.		105			
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MEDICAL	If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events	b. OUE TO (OR AS	S A CONSEQUENCE O	CEREB	ROVASCULAR E		24s. WAS AN PERFORM 1 VES 2	MED?	24b. WERE AUTOPSY I AMAILABLE PRIOR COMPLETION OF OF DEATH? 1 YES 2
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	1. DECEDENT'S NAME (First, Middle, Leat) MARIE C.	LYNC				OF			2. DATE O	F DEATH 04V	92	E 4 C	: 30	þ
1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. I	est birthday)	IF UNDER	1 YEAR	IF UNDER	24 HRS.	7. DATE O				CE (State or Foreign	1
	216-12-6033	1 □ M 2 🔀 F	91	YRS.					03	28	03	MAR	YLAND	
_	9a. FACILITY NAME (If not institution, give a	,					R LOCATIO				9c. COUNTY		RUNDEL	
DIRECTOR	FAIRFIELD NURS	SING CEN	TER			ROW	NSV:	Լևևբ			AM	VE A.	KONDEL	
E I	10a. STATE 10b. COUNT			10c. CI1	Y, TOWN					-		100	. INSIDE CITY	
늅	MARYLAND AND	NE ARUND	EL			G	LEN	BUF	NIE			1 [YES 2 THO	
FUNERAL	100. STREET AND NUMBER 308 MONTFIELI	LANE				101	ZIP CODE	1061				S.A	COUNTRY?	
	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	YES Z			f yes, sp		n, Maxicar	, Puarto Ri	(Specify Yes can, atc.)	or No- 14	Black, Wi	American Indian, nite, etc.	
B	3 ☒ Widowed 4 ☐ Divorced	IF YES, GIVE WA	H OH DATES			I YES	2 DENO	Specify				WH	ITE	
	15. DECEDENT'S EDU (Specify only highest grade			DECEDENT'S	work done			10	16b. I	CIND OF BUS	INESS/INDUS	TRY		
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	JOHN DE	VINE						ARY	- 111	GAN				
) BE	19a. INFORMANT'S NAME (Type/Print)		5	19b. MAJLIN	G ADDRES	(Street a	nd Number	or Rural F	oute Numbe	r, City or Yown	, State, Zip C	ode)	21061	
유	MARIE C. DOYL	E		308	MON.	LE TE	SLID	LAM	- GL	EN BU	KMTE	, 1111.	21001	,
		Donation 5 Other Street Page 1 20c. LOCATION - City or Town, State Of LEN HAVEN CEMETERY 12/19 GLEN BURNIE, MI												
	4 Donation 6 Other Specify	CENSEE//	GLEN	HAV			ND ADDRE		12/1	9 611	ZN BO	KMIL	, MD .	
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	23. PART I. Enter the diseases of shock, or heart faller	complications that	caused the	daath. Do									Approximate interval Betw	
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	. A	(OR AS A CONS		OF:	1			64	1.4	, _		Onset and D	
ATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	b. DUE TO	IOH AS A CONS	SEGUENCE (le N	01	M	4,	_(DU	4/<	Y		
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO ((OR AS A CONS	SEOUENCE (OF):									
CALC	PART II. Other significant condition	ons contributing to	death but no	t resulting	in the u	nderlyln	g cause	given in	Part I.	24a. WAS AN PERFOR	MED?	AM	RE AUTOPSY FIND AILABLE PRIOR TO	
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111		1							-			11	YES 2 NO	
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Σ	EXAMINER?	HOSPITAL:		_		R: rsing Hon	me 5 🗆 R		6 🗆 Other	(Specify)				
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	ICATE C	F DEATH	REG. NO.				
- 1	1. DECEDENT'S NAME (First, Middle, Last)		-			2. DATE OF DEATH		3. TIME	OF OEATH	
	MARIA B.	LEISHE	Ŕ			December		94 9:0	00 -M	
	4. SOCIAL SECURITY NUMBER		GE (In yrs. lest birthday)	IF UNDER 1 YEA	R IF UNDER 24 MRS.	7 DATE OF BIRTH		BIRTHPLACE (S		
	212-48-0887	1 □ M 2XX F	47 yrs.	MONTHS DAY		JUNE 8, 194	7	Country)		
. 1	9s. FACILITY NAME (If not institution, give	elmet and sumberl		OL OUTH TOW					MD	
œ				96. CITY, TOY	N OR LOCATION OF D	EATH	9c. COUNT	Y OF DEATH		
2	GREATER BALTIM	ORE MEDICAL	CENTER	TC	WSON		RAT.7	TMORE		
DIRECTOR	10e. STATE 10b. COUNT	Υ	10c. CIT	Y, TOWN OR LO	CATION			104 INC	PIDE CITY	
E	MD			ALTIMORE				LIM	SIDE CITY AITS?	
	10e. STREET AND NUMBER		D/	ALI INONE					ES 2 NO	
A.A.	1445 LOWMAN STREET				101. ZIP COOE 21.230	1		N OF WHAT COL	JNTRY?	
FUNERAL					212)(.S.A.		
크	11. MARITAL STATUS	12. WAS DECEDENT EVE FORCES? 1 Y	R IN U.S. ARMED		DECENDENT OF HISPA: , specify Cuban, Maxico	NIC ORIGIN? (Specify Yes	or No- 14	I. RACE - Amer Black, White, I	ican Indien,	
BY	1 Never Married 2 Married 3 Widowed 4XX Olvorced	IF YES, GIVE WAR OF	R DATES		TES 200 NO Specif			Specify:		
								٧	WHITE	
핃	15. DECEDENT'S EDU (Specify only highest grade	JCATION e completed)	16a. DECEDENT'S (Give kind of	work done during	ATION most of working	16b. KIND OF BUS	SINESS/INDUS	TRY		
Ü	Elementary/Secondary (0-12)	College (1-4 or 5+)	lite. Do NOT u	se retired.)		- FNO.		001404404		
₽ I	12тн	4	OFFICE	MANAGER		ENGI	VEEKING	COMPANY		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maiden	Surneme)			
ш	JAMES A. PRIHODA				LAURA M					
TO B	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	AOORESS (Stre	et and Number or Rural	Route Number, City or Town	n, State, Zip Co	ode)		
F	LAURE V. PRIHODA		1540 E	 FORT A 	VENUE, BALTI	MORE, MARYLAI	VD 212	30		
	20a. METHOD OF DISPOSITION		20b. PLACE AND DATE	OF DISPOSITION	(Name of	OATE 20c. LO	CATION — CIE	y or Town, Stata		
	1) (Surial 2 Cremation 3 Ran 4 Donation 5 Other (Specify)	Towar from Stata	CEDAR HILL	CEMETERY	DECEMBER	19,94 MAF	RYLAND			
1	21. SIGNATURE OF FUNERAL SERVICE LI		^	22. NAM	AND ADDRESS OF FA					
	CHARLES L. STEVENS FUNERAL HOME, INC.									
\dashv	CICO I	Juce	() 4	11501	E. FORT AVEN	UE, BALTIMORE	E, MARY		1230	
	23. PART I. Enter the diseases, or ahock, or heert failure.	List only one cause or	sed the deeth. Do o	not enter the	mode of dying, suc	h as cerdiec or respi	retory arres		pproximete terval Between	
- 1	IMMEDIATE CAUSE (Finei	0	1 1						nset and Death	
- 1	disease Dr condition	. Kon	ral Ca	ncer				12	2600M1	
		DUE TO (OR A	S A CONSEQUENCE O	F):					1200	
Z	THE STATE OF THE S	b								
CERTIFICATION	Sequentially list conditions, If any, leading to immediate	OUE TO (OR A	S A CONSEQUENCE O	F):						
5 ∥	CAUSE (Disease or Injury	с.								
E	that initieted events	DUE TO (OR A	S A CONSEQUENCE O	F):						
	resulting in death) LAST	d								
	PART II. Other significant condition	ne contribution to doct	h had met mandatum	la di conded	1-1-2-2-1-2-1					
EDICAL	TAIT II. Otto agrinicale condition	is contributing to deet	n out not resulting	in the underly	ing ceuse given in	Part I. 24a. WAS AN PERFOR		AMARLABL	JTOPSY FINDINGS LE PRIOR TO	
ă						1 🗆 YES 2	NO	OF DEATH	TION OF CAUSE	
Æ								1YES	S 2 NO	
	DID TOBACCO USE CONT	RIBUTE TO CAUSE	OF DEATH YE	S NO	UNCERTAI	N 🗆				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEA	TH (Check only o	ne)					
S	1 YES 2 NO	HOSPIFAL:	Sutpatient 3 DOA	OTHER:	lome 5 🗆 Residence	6 Other (Specify)				
Ŧ	27. MANNER OF OEATH	28e. DATE OF INJUR	ty 28b. TIM	E OF 28c.	INJURY AT	28d. DESCRIBE HOW IF	NJURY OCCUP	REO		
	Natural 5 Pending	(Month, Day, Yea	n) INJ	M 1	WORK? YES 2 NO					
B	2 Accident Investigation 3 Suicide a Could not be	28s. PLACE OF INJU	JRY — At home, ferm,			28f. LOCATION (Street a	and Number or	Bural Bouta Numi	bor	
	4 Homicide 8 Could not be	building, atc. (S	Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town, State)	INO NUMBER DE	noral mode realing	Der,	
COMPLET	29a. CERTIFIER					L				
4	(Check only CERTIFTING PHYS	ICIAN: To the best of my kn								
Ö I	2 MEDICAL EXAMINE	ER: On the basis of examine	ition end/or investigation	on, in my opinio	n, death occured at the	time, date end place, en	d due to the c	ause(s) and man	nner ee stated.	
HE C	296. SMONATURE AND TITLE OF CENTIME				29c. LICENSE NUI	MBER	29d. OATE S	IGNED (Month, D	Jay, Year)	
	Muy /1/1/1/11	O MAI)			D3052	-9	D 10	11575	4	
24	30 NAME AND ADDRESS OF PERSON WI	O COMPLETEO CAUSE OF	DEATH (ITEM 27) (Type,	Print)				1100/	/	
	PAUL CEZANO N	O GCGSN	Cherla S	T MI	m In	21209				
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SI	GNATURE	1.011	0,,,,	0.0				
	DEC 1 6 1004 /									
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` 1	FOR STATE REGISTRAR	, 12-10-	STATE OF I				MENT (MENT/	AL HYGIEN	_			
,	1. DECEDENT'S NAME (First		Roland Do	ouglas			DAIL	<u> </u>	DEA		MON	E OF DEATH	NY.	YEAR	3. TIME OF DEATH	
Ì	4. SOCIAL SECURITY NUME 217-66-372	BER	5. SEX 1 🛣 M 2 □ F	6. AGE (in yrs. last t		IF UNDER 1 Y	EAR DAYS	IF UNDER	F UNDER 24 HRS. OURS MIN. OOV 29 NOV 29 7. DATE OF BIRTH (Month, Day, Year,			199	6. BIRTH	11:34 P M IPLACE (State or Foreign ry)	
ŀ	9e. FACILITY NAME (If not in			37		YRS.	9b. CITY, TO	NOV. 30,1956 Maryla OWN OR LOCATION OF DEATH Dec. COUNTY OF DEATH								
DINECTOR	1200 W.		ARD ST.		_	I	BALT	IM	ORE	CIT	Y		N/A			
	Maryland	10b. COUNTY	v/A					DR LOCATION MORE							10d. INSIDE CITY LIMITS? 1 NO YES 2 NO	
	10e. STREET AND NUMBER		101. 2								7		10g. CIT		WHAT COUNTRY?	
. 11	10 Z 1 W • 1 11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Divo	Merried	FORCES? 1 YES 2 NO If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)								E American Indian, k, White, etc.					
-	(Specify only	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY														
	17. FATHER'S NAME (First, M James R.	Lee							Mi1	dre	d E	Middle, Maiden Wri	ght			
\ H	Arletha Le										et	Balt	i mo	Code)	Maryland	
	Arletha Lee 1802 N. Carey Street Baltimore, Māryland 200. METHOD OF DISPOSITION 1 Removal from State 200. PLACE AND DATE OF DISPOSITION Name of cemelery, cremation of Donation of Disposity 200. Location — City or Town, State 24 27 27 27 27 28 27 28 27 28 27 27															
	21. SIGNATURE OF FUNERA		ensee , Urus				22. NA	ME AN	D ADORE			5240	Re:	iste	erstown Rd ore, Md212	
	23. PART (Enter the ehock, or he immediate Cause (Fir disease or condition resulting in death)	eart fallure. nai	a. GUM	tor	ach line.	UMO	DE				h ss ca	rdiac or respi	raiory ar	rest,	Approximate Intervel Between Onset and Dasth	
	Sequantially liet conditi if sny, lasding to imme- ceuse. Entar UNDERLY	dista	DUE TO	(OR AS A	CONSEQU	ENCE OF):	_									
	CAUSE (Disease or inju that initiated events resulting in death) LAS	<i>'</i>	DUE TO	(OR AS A	CONSEOU	ENCE OF):										
	PART ii. Other algolitice	ent condition	s contributing to	daath b	ut not res	sulting in	tha unda	rlylng) cause (given in	Part i.	24a. WAS AN PERFOR 1 VES 2	MED?	24b	. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
	DID TOBACCO U 25. WAS CASE REFERRED TO EXAMINER?		RIBUTE TO CA			OF DEATH	(Check only		UNC	ERTAIN	V 🗆					
		Pending	28e. DATE OF (Month, O	INJURY			OF 28	c. INJ	URY AT	NO	28d. DE	er (Specify) S ESCRIBE HOW II		CURED		
	3 Suicide 6	Investigation Could not be determined	28e. PLACE O	F INJURY etc. (Spec	At home	, ferm, str	-	, office	•		281. LO	CATION (Street of or Town, State)	and Numbe	r or Rural I	Moute Number, MO	
	and .		CIAN: To the beet of e	my knowl	edge, desti	h occurred						tuse(e) end men	ner ee ata	ted.	e) end menner ee stated.	
	WOUDING	OF CENTIFIER	Trele						29c, LICE	ME	IBER				(Month, Day, Year)	
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BALTIMORE, MARYLAND

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DIVISION OF VITAL RECORDS, P.O. BOX

		1 - FOR STATE REGISTRAR	STATE OF MARYL			HEALTH AND F DEATH	MENTAL	HYGIEN	E		
N.		1. DECEDENT'S NAME (First, Middle, Lest)						OF DEATH		3.	TIME OF DEATH
		KIMBERLY Dene	en Lyons	(In yrs. last birthday)	LINDS		DEC		1994		11:37P M
2		219-78-1419	1 🗆 M 2 😾 F	30 YRS.	MONTHS DAYS		(Month,	Day, Year) 11, 1		Country)	ACE (State or Foreign y l.and
3 should	E E	9a. FACILITY NAME (If not institution, give str BON SECOUR HOS				n or location of d	EATH			TY OF DEAT	Н
1, 2,	ЕСТО	RESIDENCE OF DECEDENT									
permit. Pages 1,	DIRE	10e. STATE 10b. COUNTY Maryland		10c, C/1	TY, TOWN OR LOC	cation timore	-			1.5	d. INSIDE CITY LIMITS? YES 2 NO
ermi	AL	10e. STREET AND NUMBER				101. ZIP CODE			10a, CITIZ		T COUNTRY?
an. transit p	FUNER/	3001 Arunah Ave				21216			1	USA	
physician.	BY FU	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D	2 X NO	II yea,	Specify Cuben, Maxic ES 2 NO Specify Cuben	an, Puarto R	? (Specify Yas lican, atc.)	or No-	14. RACE — Black, W Specify:	American Indian, hita, alc.
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, 6 ,	ETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION completed) College (1-4 or 5 +)	16a. DECEDENT'S (Give kind of life. Do NOT u	work done during	TION most of working	16b.	KIND OF BUS	INESS/INDU	STRY	
the hospital detached to once.	COMPL	High School. 17. FATHER'S NAME (First, Middle, Lest)		Denta	al Ass	istant	_	larry H		tein,	DDS
		The second secon				16. MOTHER'S NA					
	8	Fred Joe, Jr.	_					Lyon			
retained 5 should notified	유					et and Number or Rural					ND 01016
bage page		Clarice Lyons	201	PLACE AND DATE		ranklinto	WN RO		CATION - C		MD 21216
age 6 may be director, page or must be		1 X Burial 2 Cremation 3 Remo		netery, crematory or o	ther place)						
Page Il dire		21. SIGNATURE OF FUNERAL SERVICE LICE	NSEE	Cedar I	22. NAME	emetery	ACILITYAT	ol Bal	timor	e, Ma	aryland
r death. le funera al. exami		> Kevin f	arker		2501 Balt	Gwynns Fimore, Ma	`alls rvlan	Parkwa 212	runera 216	al. Ho	mes, inc
rs af		23. PART I. Enter the diseases, or conshock, or heart failure. L	omplications that cause	d the death. Do	not antar the n	node of dying, au	ch aa cardi	ac or reaple	ratory arre	st,	Approximate
		IMMEDIATE CALICE (Final			10	/ -	0.000				Interval Batween Onset and Death
= = = = = = = = = = = = = = = = = = =		resulting in death)	SUBU-CE DUE TO (OR AS A DUE TO (OR AS A	CONSEQUENCE O	F):	norra.	se				
	Z	Sequentially list conditions,	Ruphire	ed B	2114	ander	SASA	_			
e be execut sician and c nior to buris traumatic	CATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	CONSEQUENCE D	F):		0				
	[윤]	CAUSE (Disease or injury	DUE TO (OR AS	CONSEQUENCE O	D:						
ding lygie	ERTIFIC	that initiated eventa resulting in death) LAST		TOTISEOUEINGE O	•).						
e death c ne attend Memtal Hy Jury, or	핑										
th the py the mid M	CAL	PART II. Other algnificant conditions	contributing to death b	out not reaulting	In the underly	ing causa given in	Part 1.	24a. WAS AN / PERFORI		AVE	RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE
uires tha signed Health a	EDICA						-	1 YES 2	□ NO		DEATH?
St of G	Σ	DID TOPACCO LISE CONTR	IDLITE TO CALICE C	E DEATH V	T D NO	C				1 5	YES 2 NO
	AN	DID TOBACCO USE CONTR 25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CAUSE C	26. PLACE OF DEA			N DE				
e at at	SICIAN:	EXAMINER?	HOSPITAL:		OTHER:				-		
PHYSICIAN: The this certificate with the State	PHY	27. MANNER OF DEATH	28a, DATE OF INJURY	26b. TIN		ome 5 Residence		(Specify)	LIURY OCCI	IBED	
ME PHYS		1 Natural 5 Pending	(Month, Day, Year)	IN.	JURY Y	WORK? YES 2 NO	Edd. DEG.	omoc now in		THEO	
Affe Affe	9	2 Accident Investigation 3 Suicide 6 Could not be	26e. PLACE OF INJURY	— At home, lerm,	street, fectory, of	fice	261. LOCA	TION (Street a	nd Number o	r Rural Route	Number,
ECTOR After CTOR After After death	ÉTED	4 Homicide determined	building, atc. (Spe	спу)			City o	r Town, State)			
A STATE	M.	one)	IAN: To the best of my know								Trestly cosessors
8 4 8	g	MEDICAL EXAMINER	On the besis of examination	n and/or investigation	on, in my opinion	, death occured at the	Ilme, data a	and place, and	due to the	cause(s) an	d manner as stated.
世世 90	BE	29b. SIGNATURE AND THE OF CERTIFIER	001.1			29c. LICENSE NU					onth, Day. Year)
E E B M	0	OR MANE AND ADDRESS OF THE PROPERTY OF THE PRO	Um			O.C.M	1.E.		DEC	12,	, 1994
	_	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type	Print)						

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

14.1 Penn St

31. DATE FLEEDY And GOLDS July Signature

1911 Penn Street, Baltimore, Maryland 21201.

ALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	OCCUTAL OD ATTENDING DEVOLUTARY. The four requires that the death certificate he executed within a their after
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Pages 1, 2, 3 should permit. burial-transit Page 6 may be retained by the hospital or attending physician. the use as page 5 should be detached for notified at pe must n by the funeral director, removal. examiner medicai filled in by 0 the cremation, completely other traumatic event, and com the attending physician at Mental Hydiene prior to 6 and and 23 shows any signed the been . has be Dept. certificate h item 0 the this c marked, After t 50 DIRECTOR: hours after . 28 item TO THE HOSPITAL TO THE FUNERAL (De filed within 72 h

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle (ast) 2. DATE OF DEATH 3. TIME OF DEATH 12 DAY 11 94 McKAY INEZ 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS 1 - M 2 F 217-20-40666A 82 OCT 1,1912 FLA. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RECTOR BALTO 5110 BALTIMORE NATIONAL PIKE 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD BALTO Ճ 1 YES 2 NO 5110 NUMBER FUNERAL 101. ZIP CODE 10a, CITIZEN OF WHAT COUNTRY? balto National Pike 21229 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried Specify: BLACK BY 3XXWidowed 4 ☐ Divorced 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INOUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) net of working ᆸ Elementary/Secondary (0-12) College (1-4 or 5+) SEAMSTRESS COMPL FACTORY 8TH 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) STEWART LUNDY MAE FRANCES MURRELL 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 BETTY I. DAVIS 4613 HORIZON CIRCLE APT 1 21208 BALTO. MD 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, Stata Murial 2 Cremation 3 Removal from State come KING MEMORIAL PK 4 ☐ Donation 5 ☐ Other (Specify) 121694 RANDALLSTOWN, MD 21. SIGNATURE OF FUNERAL SERVICE LIGHTSEE 22. NAME AND ADDRESS OF FACILITY MARCH f/H-WEST 4300 WABASH AVE 1 ma Son JR 23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or haert feliure. List pniy one cause on each line. interval Between IMMEDIATE CAUSE (Final disease) or condition Onset and Death lcule resulting in death) DUE TO (OR AS A CONSEQUENCE OF Lensey THE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED 1 ☐ YES 2 ☐ NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO RE UNCERTAIN N PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 - Nursing Home 5 - Raaldence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Netural 5 Pending М 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be ED 4 Homicide detarmined COMPLET 1 DERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 296. SIGNATURE AND TITLE OF CENTURE BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 2 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. MAME AND ADDRESS OF PERSON 0 31. DATE FILED (Mo) Jalin Davdeor Roydell

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO

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27. MANNER OF OEATH

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	TO THE HOSPITAL TO NET COMPANY THE NATIONAL MAY SOLVE IN THE LAW REQUIRES THAT THE DEATH CERTIFICATE DE EXECUTED WITH MAY FOUND	TO THE FUNERAL DIPORTION OF CONTINUES CONTINUED HAS been signed by the attending physician and completely filled in	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or	IMPORTANT If item 28 is marked, or item 23 shows any injury, or other traumatic event, the mu
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.	P.	9	2	=
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1 - STATE REGISTRAR		STATE OF I	MAKYLA			ENT OF ATE OF			MENTA	AL HYGIEI REG. NO					
1. DECEDENT'S NAME (First, Mic	ddle, Last)									E OF DEATH			3. TIME OF	DEATH	
ELLA M. M	IDDL	ETON							12-		24-	94	9 7	.05A M	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (//	n yrs. lest birthde	sy) IF	UNDER 1 YEAR	IF UNDE	9 24 HRS.	7. DATE	OF BIRTH	4-	6. BIRTH	PLACE (State		
215-14-0335		1 M 2 KF		85 YAS	S. MOI	THS DAYS	HOURS	MIN.	L	oth, Day, Year)	000	Countr			
9a. FACILITY NAME (If not institu	tion, give s	treet and number)		0)	9b	CITY, TOWN	OR LOCATI	ION OF O	EMINED HTAS		909	JNTY OF D	EATH CANT	-	
INNS OF EVER	CRFF	N N V			D	ALTIMO	ידכו				DAT				
RESIDENCE OF DECE		. V 14 44			DI	4 TT TIME	RE	_			BAL	TIMOF	RE CIT	<u>Y</u>	
10a. STATE 10	b. COUNTY	r		10c.	CITY, TO	WN OR LOCA	TION					1	10d. INSIDE		
MARYLAND BALTIMORE CIT			ſΥ	_	BAL	'IMORE							1 YES		
10e. STREET AND NUMBER							H. ZIP COD	E			10g. CI	TIZEN OF V	VHAT COUNT	RY?	
508 NORTH FUL	TON A	AVENUE				2	1223				IIV.	TTED	STATE	C	
11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN	U.S. ARMED		13. WAS DE	CENDENT			IN? (Specify Ye		14. RACE	- American		
1 Never Married 2 Married FORCES? 1 FYES, GIVE W							ocity Cubi			Rican, atc.)			Black, White, etc.		
3 Widowed 4 Divorced	1						×					-		10	
15. DECEDE (Specify only hig	NT'S EDU	CATION completed)		16a. DECEDEN	T'S USU	AL OCCUPAT	ON ost of worki	na	16	b. KIND OF BU	SINESS/IN	DUSTRY	DLAC	K	
(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +			+)	(Give kind of work done during most of working life. Do NOT use retired.)											
5				DOMES	STIC										
17. FATHER'S NAME (First, Middle	e, Last)						18. MOT	HER'S NA	ME (First,	Middle, Maider	Sumeme)			-	
	INKNO	NWO						I	ELLA	MIDDL	ETON				
194. INFORMANT'S NAME (Type/	Print)			19b. MAIL	ING ADO	PRESS (Street	and Numbe	r or Rural i	Route Nun	nber, City or Tox	vn, State, Z	p Code)		-	
RUBY ROGERS				508	NOF	RTH FU	LTON	AVE	UE :	BALTIM	ORE,	MD	21223		
20a. METHOD OF DISPOSITION 1 D Burlal 2 Cremation	3 □ Reme	oval from State		PLACE AND DA			arria of		OA"	TE 20c. L0	OCATION -	City or To	wn, State		
4 Donation 5 Other (Spe			_ Cerme		,	ON CE	\T	12	2-17	-94 B	ALTIN	MORE,	MD		
21. SIGNATURE OF FUNERAL SE	RVICE LIC	ENSEE				22. NAME A	ND ADDRE	SS OF FA	CILITY						
* alour 7	- M	Mu	26			CALVI.	и т.	MTTT		S F.S.					
23. PART I. Enter the disea		complications the	t sourced	the death D		Gary	P. N	larcr	1 F.1	H.,P.A	.)	BALT	IMORE		
ahock, or hasrt	fsilura.	List only ons cau	les on as	ch lins.	o not a	inter tha me	oda or dy	ing, suc	n aa car	diac or resp	iratory a	resi,		oximate rai Between	
iMMEDIATE CAUSE (Finsi disease or condition		CHIE											Onse	t and Daath	
resulting in death)		eCHF													
				CONSEQUENCE	OF):								-		
Sequentially list conditions		ASCVD													
if sny, isading to immediat	s	OUE TO	(OR AS A	CONSEQUENCE	OF):								{		
cause, Entar UNDERLYING CAUSE (Disease or Injury	< -	с													
that initisted events resulting in death) LAST		DUE TO	(OR AS A	CONSEQUENCE	OF):										
In death, end		d		·									-		
PART II. Other aignificant of	condition	s contributing to	dssth bu	it not resultin	ng in th	e undsriyir	g causs	givan in	Part I.	24a, WAS AN		24b.	WERE AUTOF	SY FINDINGS	

DEMENTIA DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)

1 Inpetient 2 ER/Outpetient 3 DOA

Home 5 - Rasidence 6 - Other (Specify)

BALTO. MD 21208

26d. DESCRIBE HOW INJURY OCCURED

COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO

28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26c. INJURY AT WORK? Natural XX м 1 YES 2 NO Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 261. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicida 6 Could not be determined

29a, CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as atteted.

OTHER:

4 XN

2 MEDICAL EXAM willigation, in my opinion, death occured at the fima, date and place, and due to the cause(s) and manner as atted.

296. BIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) ▶ 12-15-94

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (150H, Print)

1994

HOSPITAL:

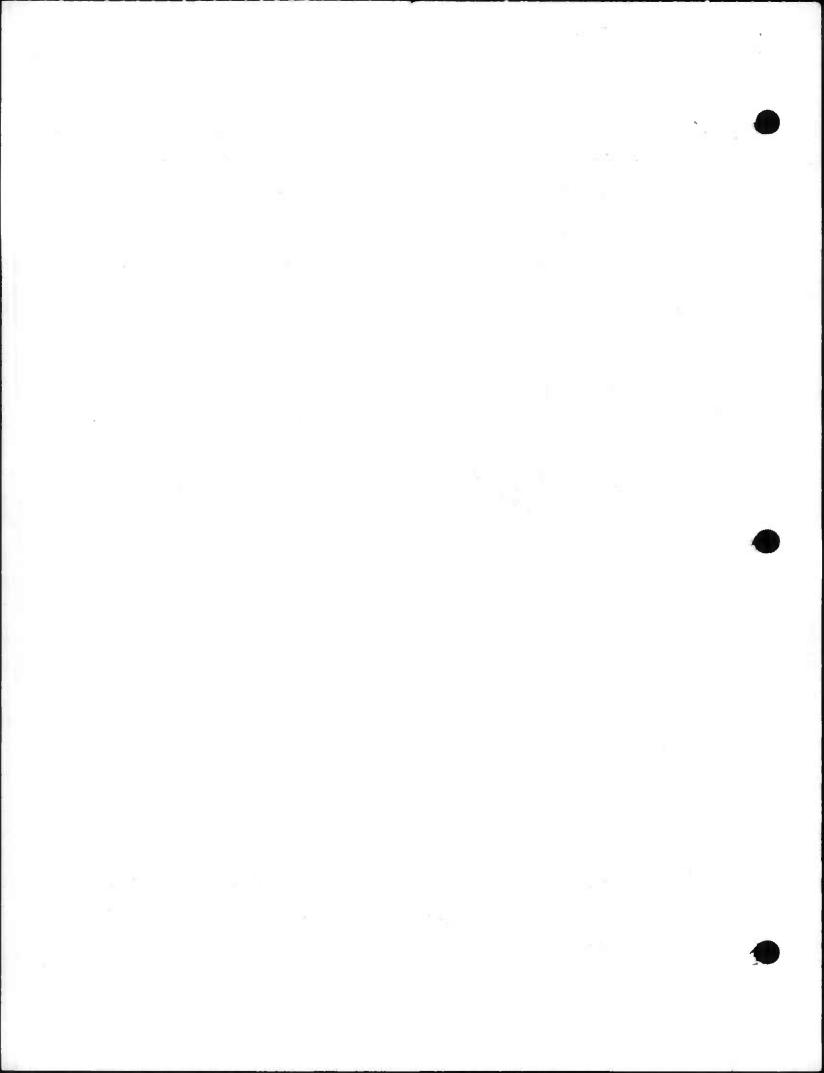
ALLEN HETTLEMAN REISTERSTOWN ROAD 31. DATE FILEO (Month, Day, Year)

32 REGISTRAR'S SIGNATURE

OM .

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-718 12/27/94 t.t

		REGISTRAR			EKITE	CALE OF	DEATH	REG	. NO.			
		1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEA	ГН	3. TIME OF DEATH	_	
		RICHARD C.	MINNICK					DEC.	0.9	94 5:00P		
		4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. Id	st birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF BIRT	и	8. BIRTHPLACE (State or Foreign	-	
		213-52-0696	t 🔀 M 2 🗆 F	38	YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Ve 09/21	71956	Country) MD		
pino		9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY, TOWN	OR LOCATION OF			TY OF DEATH	_	
্য ব	Œ	GOOD SAMARITA	N HOSPT	ГАТ.			TIMORE					
1, 2,	1	RESIDENCE OF DECEDENT										
iges	DIRECTOR	10s. STATE 10b. COUNT	Y			, TOWN OR LOCA	ATION			10d. INSIDE CITY LIMITS?	_	
£.	ā	MD Balt	imore		Balt	imore				1 YES 2 NO		
JE J	AL	10e. STREET AND NUMBER				1	of. ZIP CODE		10g. CITIZ	EN OF WHAT COUNTRY?	-	
. usit	FUNERAL	333 Elinor Aven	ue				21236			U.S.A		
O sician al-tra	5	11. MARITAL STATUS	12. WAS DECEDENT			13. WAS DE	CENDENT OF HISP	ANIC ORIGIN? (Speci	fy Yes or No-	14. RACE - American Indian,	-	
Day phy		1 Never Married 2 Married	FORCES? 1 [IF YES, GIVE WA		NO		pecify Cuban, Maxi S 2 X NO Spe	can, Puarto Rican, et	C.)	Black, White, atc.		
5-0020 ending physician. as the burial-transit permit. Pages 1, 2, 3 should	ВУ	3 Wildowed 4 Divorced								SpecifyWhite		
21215-0020 al or attending physic for use as the burial.	ᇤ	15. DECEDENT'S EDU (Specify only highest grade		18a. D	ECEDENT'S I	USUAL OCCUPAT	ION lost of working	18b, KIND O	F BUSINESS/IND	USTRY	_	
21 al or for t		Elementary/Secondary (0-12)	College (1-4 or 5+)			ork done during m e retired.)						
ched ched	₩ P	12		Dry	/ Clea	ner		Dry	Cleanin	g		
YLAND 21215-0020 by the hospital or attending physician. be detached for use as the burial-tran at once.	COMPLETED	17. FATHER'S NAME (First, Middle, Last)						NAME (First, Middle, M				
3 6 € €	BE	Richard C. Minn	ick Sr.				Jeann	ett Adams				
MARYLAND retained by the hospit should be detached notified at once.	2	19a. INFORMANT'S NAME (Type/Print)		1				al Route Number, City of				
be re ige 5	۱	Jeannette Minn	ick		333 E	Clinor A	lve. Bal	timore, M	aryland	21236		
RA may		20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Ram	ovel from State	20b. PLACE	AND DATE O	F DISPOSITION (A	lame of			City or Town, State		
AO recto	. 1	4 Donation 5 Other (Specify)	over nom state			emeters	7	12/12/94	Baltim	ore, MD		
Pag . Pag		21. SIGNATORE OF FUNERAL SERVICE LIC	EMSES /	70				FACILITY The	Dinnel	Funeral Home	T	
hours after death. Page 6 may be filled in by the funeral director, page on, or removal.		bake 11	Selb. V			7110	Belair 1	Road Bält	b.PMD-2	Funeral Home	1	
	\neg	23. PART I. Enter the diseases, or o	omeliations that	offuned the d	eath Do n	ot enter the m	ode of dulps or	ah oo saadlaa aa			_	
		shock, or heatt fallure.	List only one caus	on each iin	e.	ot enter the m	oue or aying, se	oci sa cardiac or	respiratory arri	interval Between		
		IMMEDIATE CAUSE (Finel disease or condition	00001115		03:10 11	3:0 V 7 C A 3: 7 /	211			Onset and Das	nt	
P.O. BOX 68760 th certificate be executed within an ending physician and completely filled it Hygiene prior to burial, cremation, or other traumatic event, the r		resulting in death)	a. COCAINE	OR AS A CONS			JN				_	
executed with and complete o burial, crem			DOE 10 (1	OH AS A CONS	EOUENCE OF):						
68 and and burn	O	Sequentielly list conditions,	b. DUE TO (OR AS A CONSI	OUENCE OF						_	
BOX	AT	if any, leading to immediate cause. Enter UNDERLYING										
.O. BOX certificate be ding physician tygiene prior tr	윤	CAUSE (Diseese or Injury	c. DUE TO (OR AS A CONSI	EQUENCE OF):					-	
Cortificate be ex nding physician a Hygiene prior to or other traum.	E	thet initiated eventa reaulting in death) LAST				<i>r</i> -				j		
DS, P.O he death certi the attending Mental Hygie	CERTIFICATION		d,							<u> </u>	_	
이 원 후 등 등		PART II. Other aignificent condition	a contributing to d	death but not	resulting in	the underlying	ng cause given i	n Part I. 24s. W	S AN AUTOPSY	24b. WERE AUTOPSY FINDING	35	
COR that the the ed by the and the and line	DICAL							1 1/	RFORMED? ES 2 \(\subseteq NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE		
ECOF puires that signed I Health a	w II								2 1 110	DF DEATH?		
AL RE ne law requi has been s Dept. of H	Σ.	DID TOBACCO USE CONT	RIBLITE TO CAL	ISE OF DEA	ATH YE	S D NO I	UNCERTA	IN D		T TES 2 NO		
	HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	KIDOTE TO CAL			H (Check only one					_	
VITAL JAN: The law rificate has re State Dep or Item 23	2	EXAMINER?	HOSPITAL:			OTHER:					-	
L 등 등학 기	¥	27. MANNER OF DEATH	28a. DATE OF II		28b. TIME		JURY AT	8 Other (Specify 28d. DESCRIBE H		IIDED	-	
NG PHYSICI fler this cer eath with th marked, o	Ω.	1 Netural 5 Pending	(Month, Day FOUND: 12	y. Year)	FOUNDL	JRY W	ORK? YES 2 ((NO		OW INJUNT OCC	OWED		
ONG DING After death	BY	2 Accident Investigation 3 Suicida & XX Could not be			1.00	treet, factory, offi	,,,,	UNKNOWN	tenet and Mumber	or Dunt Bouts Mumber	_	
		3 Suicida 8 Could not be 4 Homicide detarmined	building, a	tc. (Specify)		OWELLING		City or Town, BALTIMORE	State) 5219 Y	ORK ROAD		
Z 2 2 %	iii	29a. CERTIFIER			<u> </u>				,		_	
BURGE SING		(Check only 1 CERTIFYING PHYSI	CIAN: To the best of n									
DIVISI TAL DR ATTEN AL DIRECTOR: 72 hours after If item 28 i	MPL	one)	R: On the beels of exa	minstion and/or	Investigation	i, in my opinion,	death occured at ti	na time, data and plac	a, and due to the	cause(s) and manner as stated.		
14 14 14 14	COMPL	2 MEDICAL EXAMINE									_	
14 14 14 14	8	2 MEDICAL EXAMINE					29c. LICENSE N		29d. DATE	SIGNED (Month, Day, Year)		
DIN TO THE HOSPITAL DR TO THE FUNERAL DIRE be filed within 72 hour IMPORTANT: If Item	BE CO	2 X MEDICAL EXAMINE		m	D.		O.C.			EC . 10/94		
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II	8	2 X MEDICAL EXAMINE	O COMPLETED CANSE		, , ,,	,	0.C.	M.E.	▶ D	EC. 10/94	-	
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II	BE CO	2 MEDICAL EXAMINE 2 MEDICAL EX	O COMPLETED CANSE		, , ,,	,	0.C.	M.E.	▶ D		_	
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II	BE CO	2 MEDICAL EXAMINE 210. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CANSE		, , ,,	,	0.C.	M.E.	▶ D	EC. 10/94	_	



DIVISION OF VITAL RECORDS, P.O. BOX 68760

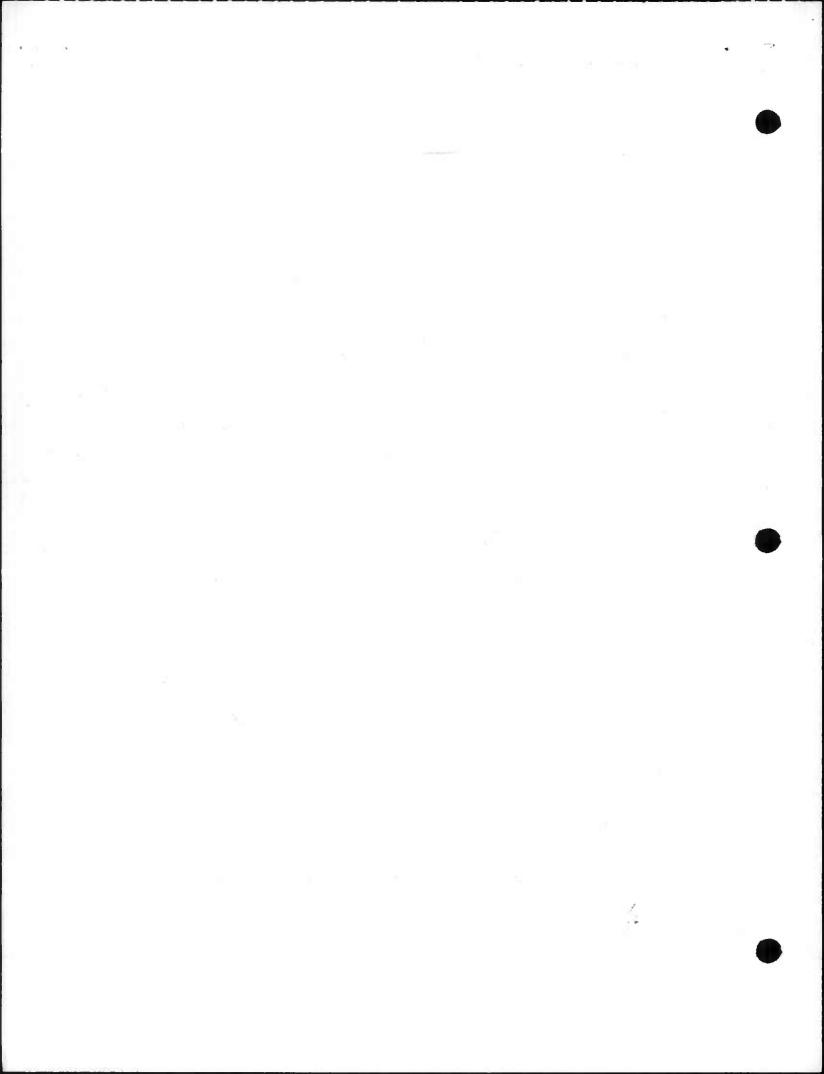
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

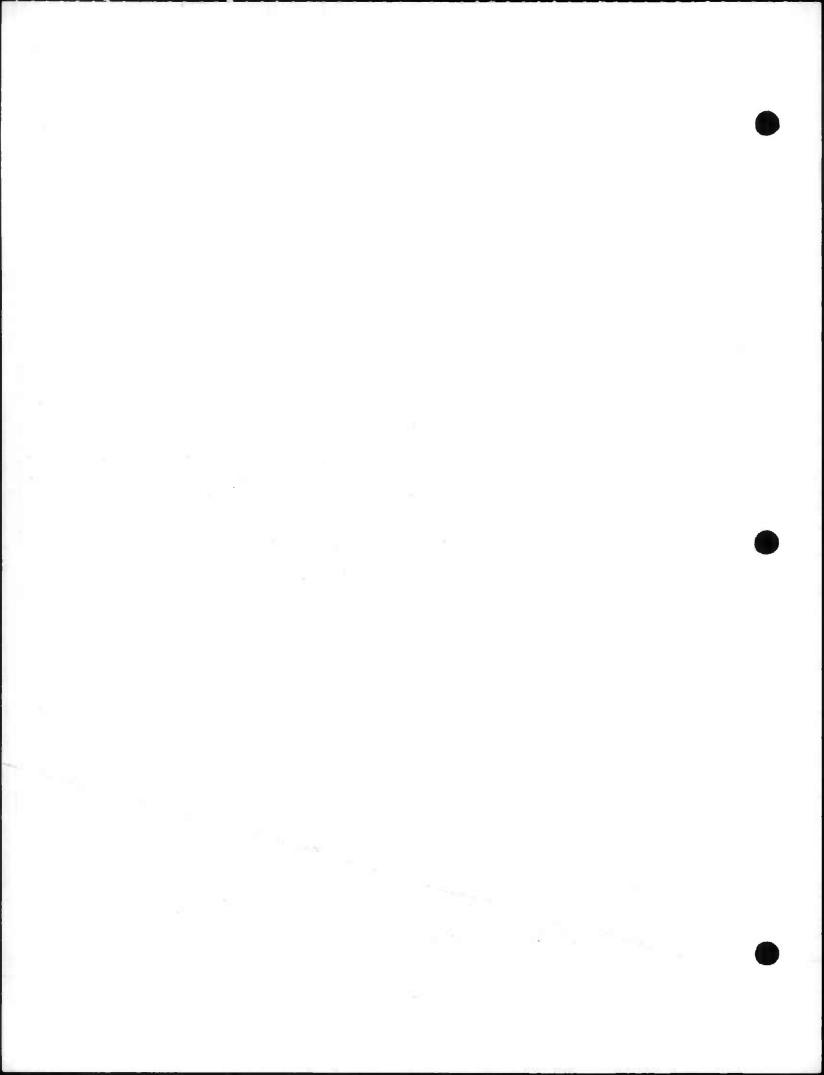
STATE OF MARYI AND / DEPARTMENT

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.												
3	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH: DAY YEAR 3. TIME OF DEATH												
	1/10N2 MILLUN 12 10 94 11:00 PM 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign												
	063-42-6447 1 M 2 DF WONTHS DAYS HOURS MIN. (Month, Day, Year) 49 Country)												
-	9e. FACILITY NAME (If not inetitution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH												
TO.	Mercy 1705 DITAL BOLTIMORE CITY N/A												
DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS?												
	1 Pres 2 NO												
FUNERAL	1107 Barclay Street 21202 10g. CITIZEN OF WNAT COUNTRY?												
FU	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No— Black, White, atc.) 14. RACE — American Indian, Black, White, atc.												
ВУ	3 Widowed 4 Ovorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify: BI ACIL												
COMPLETED	15. DECEDENT'S EQUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired,) 18b. KIND OF BUSINESS/INDUSTRY												
IPLE	Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME												
COM	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)												
BE	LOUIS MOORE DOROTHY PAYTON												
5	19a. INFORMANT'S NAME (Type/Print) JERI DICKERSON 17/3 LEMMON STREET; BALTIMORE MD, 2/223												
	20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION / Name of cemptery, crematory or other place) 20c. LOCATION — City or Town, State												
	21 SIGNATURE OF ETHERAL SERVICE LICENSEE												
	JOSEPH H, BROWN JR, FUNERAL HOME												
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate												
	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onest and Death												
	disease or condition a. META STATIC LUNG CANCER												
z	Sequentially list conditions b. Human /mmunoDEFICIENCY VRUS (HIV)												
ATIO	If any, is ading to immediate												
FIC	CAUSE (Disesse or Injury CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF):												
CERTIFICATION	resulting in death) LAST												
CAL C	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY FINDINGS												
EDIC	PERFORMED? 1 YES 2 NO COMPLETION OF CAUSE DF DEATH?												
Σ	1 YES 2 NO												
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)												
SIC	EXAMINER? 1 YES 2 NO NO NO NO NO NO NO NO NO NO												
PHY	27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? WORK? 28d. DESCRIBE HOW INJURY OCCURED												
B	Accident Investigation M 1 YES 2 NO												
TED	3 Suicide 8 Could not be determined Could not be determined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, Stete) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)												
COMPLETED	29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, end due to the cause(e) end manner ee stated.												
	2 MEDICAL EXAMINER: On the beels of examination and/or investigation, in my opinion, death occured at the time, data and place, end due to the ceuse(e) and manner ee stated.												
) BE	296. HICKORSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) TETPLEY LOTALKAR PHYSICIAN WILLERS IT Y MODES 290. DATE SIGNED (Month, Day, Year)												
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) JOHNSON J												
	31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE												
	DEC 1 6 1994 Atri Denien Russes												



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		_	REGISTRAR		CENTIF	ICATE	F DEATH	R	EG. NO.		
			1. DECEDENT'S NAME (First, Middle, Last) ERNEST	MAKE	R			2. DATE OF E	DEATH DAY	YEAR 3. TIME OF DEATH	
			010	5. SEX 6. AGE (in yrs. lest birthdey)	IF UNDER 1 YEAR		7. DATE OF B (Month, Day	y, Year)	8. BIRTHPLACE (State or Foreign County)	
	should	~	9e. FACILITY NAME (If not institution, give street	et and number)	NEL	-	/N OR LOCATION OF D	EATH		NTY OF DEATH	
	1, 2, 3	CTOR	LIBERTY ME	nical Le	אוכוכ	15.	ALTIMORG	m() 11	312	USA	
	III. 18955	DIRE	., ,	BALT CIT	10c. CIT	Y, TOWN OR LO	RALTIN	nore		10d. INSIDE CITY LIMITS? 1 YES 2 NO	
E	ariski perimit.	FUNERAL	10e. STREET AND NUMBER 2122 BA	addish 1	Aug.		2121	Ь	10g. CITI	ZEN OF WHAT COUNTRY?	
9 8	ure contain and	β	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced	2. WAS DECEDENT EVER IN FORCES? 1 _ YES IF YES, GIVE WAR OR DA	2 NO	If yes,	DECENDENT OF HISPAI , specify Cuben, Mexica YES 2 NO Specific	in, Puerto Rican		14. RACE — American Indien, Black, White, atc. Specify:	
	200	ETED	15. DECEDENT'S EDUCAT (Specify only highest grade co	mpleted)	16a. DECEDENT'S (Give kind of tilfle, Do NOT us	work done during	ATION most of working	16b. KIN	D OF BUSINESS/IND	DUSTRY	
AND 21 he hospital or		COMPLE	Elementary/Secondary (0-12) High School	College (1-4 or 5 +)	Carpe			U.S	. Govern	ment/Ft Meade	
YLAI by the h		- 1	17. FATHER'S NAME (First, Middle, Last)				200000000000000000000000000000000000000		e, Maiden Surneme)		
MAR retained to		TO BE	Albert Maker 19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Stre	Map et and Number or Rural	el. Wal		Code)	
E, be	, 21	F	Phyllis O. Make				dish Ave		Baltimor		
0 0	Snu		1 Ramovi	ol from State cem	PLACE AND DATE (etery, crematory or o Veteran	cher place) Cemeter	cv/Garrison	Dec 16	Owings	Mills Maryland	
ALTIM death. Page	examiner		21. SIGNATURE OF UNERAL SERVICE LICEN	ISEE)	7,	250	T OWAITING I	Falls P	ter Fune	ral Homes, Inc	
after B	or removal.	\exists	23. PART I. Enter the diseasea, or cor	mplicetions that ceused	I the deeth. Do r	Bal.	timore, Ma	aryland	21216 or respiratory arr	est, Approximate	
things hours	emation, or r		ahock, or heert feilure. Lie IMMEDIATE CAUSE (Finel disease or condition recuiting in deeth) e.	Post	OBSI		ie Pma	unom	ام	Interval Between Onset end Daath	
executed wi	ic eve	_		DUE TO (OR AS A	CONSEQUENCE OF	Buts	· denice				
be exec	nor to buri	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A	CONSEQUENCE OF	Pi:	0	20	0,,0		
ortificate	glene pr	LIFIC	CAUSE (Disease or Injury that Initiated evente Due TO (OR AS A CONSEQUENCE OF):								
death or	ntal Hy	CER	resulting in deeth) LAST								
1 m	th and Menta any injury,	EDICAL	PART II. Other significent conditions	contributing to death b	ut not resulting	in the underly	ying ceuee given in	Part I. 24a	. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE	
	K Hea	MED						_ 1	YES 2 KNO	OF DEATH?	
AL KE	23 Jepi	AN:	DID TOBACCO USE CONTRIL		F DEATH YE			N 🗆			
VIIIAN: The	or item	PHYSICIAN:	EXAMINER?	IOSPITAL:		OTHER:	fome 5 🗆 Rasidence	8 Other (Spi	ecify)		
PHYSIC PHYSIC	marked, o	N N	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIM INJ	IURY	INJURY AT WORK? YES 2 NO	28d. DESCRIB	MI A	CURED	
OF ATTENDING PHYSICIAN: The law	6	ED BY	2 Accident Investigation 3 Suicide 8 Could not be determined	28a. PLACE OF INJURY building, atc. (Spec	- At home, farm,	76		281. LOCATION City or Tox	wn, State)	or Rural Route Number,	
8	1 F	PLE		N: To the best of my knowl	edge, death occurre	1 1	late and piece, end due	to the cause(e)	ond menner as atat	ed.	
THE HOSPITAL	V	S/	-	On the basis of examination	end/or investigation	on, in my opinion	_		place, end due to th	a couse(s) and manner oo stated.	
1 P E	De fled	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER	3	Physica			0215	•	E SIGNED (Month, Day, Year)	
1			30. NAME AND ADDRESS OF PERSON WHO C	473	TH (ITEM 27) (Typo.	e Megg	uts Ave	. BA	MORE	MU 31212	
			31. DATE FILED (MONDE CL. 6 198	32. REGISTRAR'S SIGN	West Randal	Ų					
				1							



FOR 1 . STATE

TO BE COMPLETED BY FUNERAL DIRECTOR

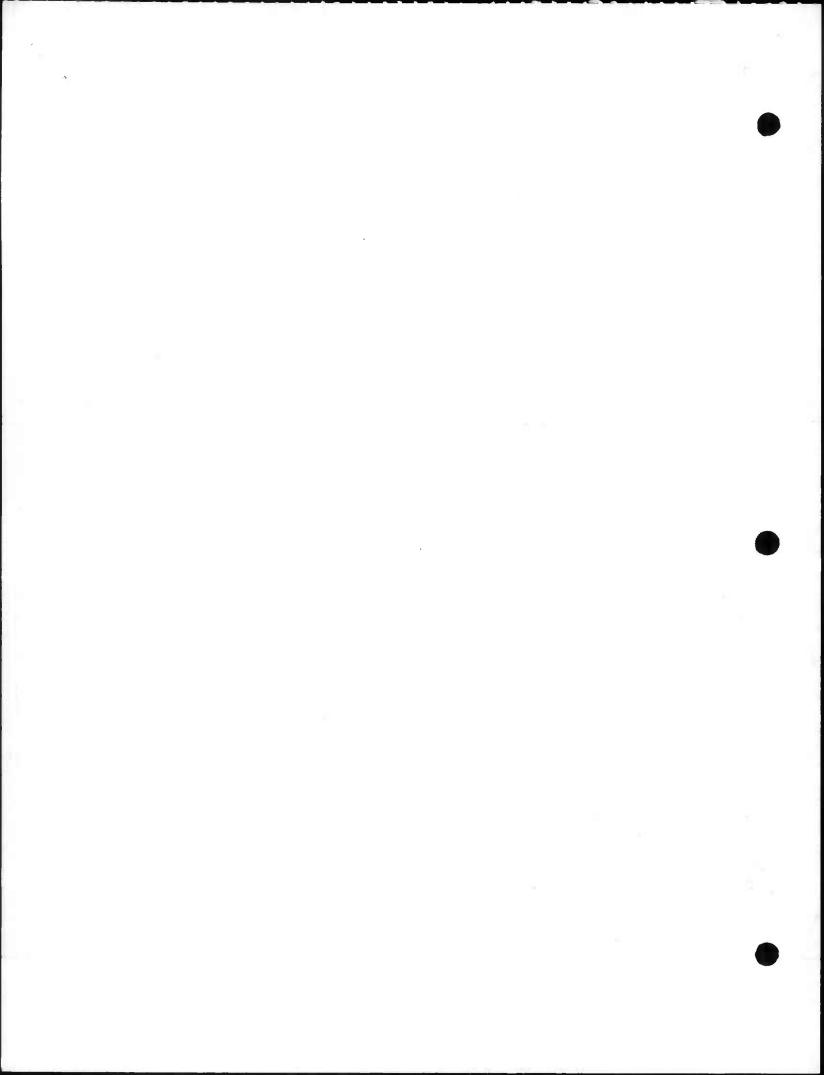
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LIMERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

STIANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

REGISTRAR				CERTIF	ICATE	E OF	DEATH		REG. NO			
1. DECEDENT'S NAME (First	, Middle, Lest)							2. DATE OF	DEATH	-		3. TIME OF DEATN
ANN	McLE	NDON M	IURPH	Y				Dec.	13	1904	YEAR	5:39 A. M
4. SOCIAL SECURITY NUME		5. SEX		yrs, last birthday)	IF UNDER	1 VEAD	IF UNDER 24 HRS.	7. DATE OF		1774		HPLACE (State or Foreign
431-42-8098		1 🗆 M 2 😾 F	67		MONTHS	DAYS	HOURS MIN.	Aug /	Day, Year)		Ark	ansas
90. FACILITY NAME (If not in 7030 Johnn	ycake					town o	OR LOCATION OF D	EATN			nty of d	ore County
RESIDENCE OF DEC	10b. COUNT	v		100 017	Y, TOWN C	D 1001						
	12.5											10d. INSIDE CITY LIMITS?
_Maryland	Bal	timore Co		I	Balti	Lmor	e					1 TYES 2 NO
10e. STREET AND NUMBER		D 1				101	. ZIP CODE			- 1		WHAT COUNTRY?
7030 John	inycak						21244				SA	
11. MARITAL STATUS		12. WAS DECEDEN FORCES? 1			13.	WAS DEC	ENDENT OF HISPA ecify Cuben, Mexico	NIC ORIGIN? (Specify Yes	or No-	14. RAC	E — American Indian, ik, White, etc.
1 Never Married 2 🔀 3 Wildowed 4 Divo		IF YES, GIVE V				1 TYES	2 NO Specif	ly:	mo, etc.)		Spec	
15. DEC	EDENT'S EDU	CATION		ISe. DECEDENT'S	USUAL O	CCUPATIO	ON	16b. K	IND OF BUS	SINESS/INI	DUSTRY	WILLE
Elementery/Secondary (0	y highest grade	College (1-4 or 5	,	(Give kind of a life. Do NOT us	work done i se retired.)	during mo	st of working					
Environmenty Geography (G		4 years	''	Cleri	,			Dor	.+ .	e pa	0000	e for SSA
17. FATHER'S NAME (First, M		+ years		CIELI							nanc	E TOT DOW
							16. MOTNER'S NA			Surname)		
George Will		cLendon					Ollie					
19a. INFORMANT'S NAME (7	ype/Print)			19b. MAILING	ADDRESS	(Street a	and Number or Rural	Route Number,	City or Tow	n, Statu, Zij	Code)	
Mr. George	R. Mu	rphy		7030	Johnr	пуса	ke Rd.	Baltin	nore,	MD	21:	244
20a. METNOD OF DISPOSIT		=17.F.T.S.+4x32		LACE AND DATE	OF DISPOS			DATE	-		City or To	own, State
1 🔀 Burial 2 🗆 Cremetion 4 🗆 Donation 5 🗀 Other	n 3 ∐ Rem (Specify)	oval from Stata		ery, cremetory or o				12 10				
21. SIGNATURE OF FUNERA		CENSEE	1 WO	odlawn (ND ADDRESS OF FA	12-16	ol Moo	dlaw	n, M	D
.01	11	1 0)	1				Byers .		1 Din	recto	rs.	Inc.
John	KI	ay me				-	Liberty 1					
23. PART I. Enter the di	isesses, or	complications the	t caused 1	the desth. Do r	ot enter	the mo	de of dving au	th as cardia	c or read	TISEC	WII 5	Approximata
ahock, or he	eart fallure.	List only one cau	se on esc	h line.			ar or aying, add	ni de cercia	o or reap	raiory an	· cat,	Interval Between
IMMEDIATE CAUSE (Find disease or condition	nal	1										Onset and Death
resulting in death)	\rightarrow	a. Dru	m t	tumor 1 year								
		DUE TO	(OR AS A C	ONSEQUENCE OF	F):							0
		b.										
Sequentially list conditi if any, leading to immed		DUE TO	(OR AS A C	ONSEQUENCE OF	F):							
cause. Enter UNDERLYI CAUSE (Disease or Inju		C.										
that initiated events	7	DUE TO	(OR AS A C	OR AS A CONSEQUENCE OF):								
reauiting in death) LAS	т 📗											
		0										
PART II. Other significa	nt condition	a contributing to	death but	not resulting i	in the un	deriying	csuse given in	Part I. 24	le. WAS AN		24b	. WERE AUTOPSY FINDINGS
									PERFOR	-		AVAILABLE PRIOR TO COMPLETION OF CAUSE
								_ '	YES 2	NIO		OF DEATH?
						-	/					1 TES 2 DINO
DID TOBACCO U		RIBUTE TO CA	USE OF	DEATH YE	S 🔲 1	10 P	UNCERTAI	N				
25. WAS CASE REFERRED TO EXAMINER?	MEDICAL	HOSPITAL:	26	PLACE OF DEAT								
1 - YES 2 - NO		1 Inpetient 2	ER/Output	lent 3 DOA	OTHER		e 5 Mesidence	8 Other (S	(pecify)			
27. MANNER OF DEATN		28a. DATE OF		28b. TIM	E OF	28c. INJ	URY AT	28d. DESCR		NJURY OC	CURED	
	Pending	(Month, D	my, Year)	INJ	URY		RK? (ES 2 NO					
a	investigation	28a PLACE O	E IM ILIDY	- At home, ferm, s	dured fact							
	Could not be determined	building,	etc. (Specify)	Rreat, fact	ory, omic			ON (Street a fown, State)	ind Number	or Rural I	Route Number,
DOS OFFICIENTS	-											
		CIAN: To the best of										
2 MEDI	CAL EXAMINE	R: On the basis of ex	camination a	ind/or investigatio	n, In my o	pinion, d	eath occured at the	time, dete an	d place, en	d due to th	ne ceuse(e	e) end manner se stated.
296. SIGNATURE AND TITLE	OF CERTIFIE	3					29c. LICENSE NUI	MBER		29d. DAT	E SIGNED	(Month, Day, Year)
Grann 1	0+1-	An	Λ				D4083					3/94
30. NAME AND ADDRESS OF	PERSON WA	O COMPLETED CAUS	F OF DEAT	N //TEM AT /E	Outset						1	117
1 /						- 0	4	000			C	
		AUIANU			TAVE	- 13	ALTIMO	TILE, M	JD 5	122	7	
DEC1 6 19	94	32 A REGISTRA	R'S TENAS	11								



TO THE HISPITAL OF ALTHOURS PHISICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Merital Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	REGISTRAR				CERTIF	ICALL	= UF	DEA	I H	F	REG. NO.				
	1. DECEDENT'S NAME (First			-	2. DATE OF DEATH MONTH						AY .	YEAR	3. TIME OF DEAT		
	Alvin John 4. SOCIAL SECURITY NUMBER	1 105 //						Dec.	1	1 .	1994	3:55			
	152-07-988	5. SEX	6. AGE (In y	rs. last birthday) YRS.	IF UNDER	DAYS	HOURS	24 HRS. MIN.	7. DATE OF 1	BIRTH 19. Year)	1913	Count	HPLACE (State or Fo try) W York	reign	
	9a. FACILITY NAME (If not in	estitution, give st	treet and number)			9b. CITY	. TOWN (OR LOCATI	ON OF DE		,		INTY OF D		
œ	Greater Ba	1timor	co Modice	1 Con	tor			, MD	011 01 02				timo		
임	RESIDENCE OF DEC		re medica	ii cen	LEI	100	VSUII	, rid				Ват	r TillO1	Le	
DIRECTOR	10e. STATE	10b. COUNTY	,		10c. CIT	Y, TOWN C	OR LOCAT	ION						10d. INSIDE CITY	
뚬	MD	Balti	imore		Pho	enix	(LIMITS?	NO.
	10e. STREET AND NUMBER						101	, ZIP CODI	E			10a. CIT	IZEN OF Y	WHAT COUNTRY?	
FUNERAL	2408 Stanv	vick Ro	1.				2113	1			USA				
5	11. MARITAL STATUS		12. WAS DECEDEN			13.	WAS DEC	ENDENT C	F HISPAN	IC ORIGIN? (S	pecify Yes	or No-	14. RACI	E — American India	ın,
	1 Never Married 2.4		FORCES? 1				If yes, sp 1 ☐ YES	ecify Cube 2X NO	n, Mexicen Specify:	n, Puerto Rica	n, etc.)			k, White, etc.	
ВУ	3 Wildowed 4 Divo	erced											WI	nite	
COMPLETED		EDENT'S EDUC y highest grade		16	ia. DECEDENT'S	USUAL O	CCUPATIO	ON st of working	20	16b. KIP	O OF BUS	SINESS/INI	DUSTRY		
9	Elementary/Secondary (0		College (1-4 or 5	r)	(Give kind of title. Do NOT us	se retired.)		01 01 1101101	. 9						
MP	12		4		Engine	er				Co	mmun	icat	ions		
Ö	17. FATHER'S NAME (First, M	liddle, Last)			10000			18. MOTI	HER'S NAM	ME (First, Midd	le, Maiden	Surname)			
BE	John Jose	eph Nik	co1a					Ma	ary (Colgan					
	19a. INFORMANT'S NAME (7	Type/Print)			19b. MAILING	ADDRESS	S (Street e	nd Number	or Rural R	loute Number, (City or Town	n, State, Zij	p Code)		
일	Margaret	F. Nik	co1a		2408	Star	nwic	k Roa	ad, F	hoeni	x. M	D 21	131		
	20s. METHOD OF DISPOSIT	ION		20b. PL	ACE AND DATE	OF DISPOS	ITION /Na	me of		DATE	20c. LO	CATION —	-	own. State	
ŀ	1 X Burial 2 Crematic		oval from State	Dula	ney Va	Llev	Mem	. Gan	rd. 1	12/14/	94	Timo	nium.	, MD	
	21. SIGNAPURE OF FUNERA	L SERVICE LIC	ENSEE A			22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home									
ì	100	1,1	(Vax												
\dashv	a rigo	nn	·uu	4			10 1	W. Pa	adoni	la Rd.	, Ti	moni	ım, N	MD 21093	
	23. PART I. Enter the dishock, of his immediate CAUSE (Fir disease or condition resulting in death)	eert fallure. I	List only one can	Ev	fine.	Fa	the mo	de br dyl	Ing, such	n es cerdiec	or respi	ratory ar	rest,	Approxima interval Be Onset and	tween
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST														
- 11	PART II. Other significe	nt condition	s contributing to	death but	not resulting	In the un	dedula		nium in f	Dort I or	. WAS AN	ALITORON	1	1	
DICAL			o donating to	Gently Ball	not resulting	iii liie ur	ideriyiiiş	, cause (Jiven in r	Part 1. 241	PERFOR		240	AVAILABLE PRIOR 1	ro
										1 {	YES 2	- NO		COMPLETION OF CO OF DEATH?	AUSE
Σ														1 YES 2 N	10
CIAN: M	DID TOBACCO U		KIBUIE IO CA					UNC	ERTAIN	1 🗆 📗				NA	
₫	EXAMINER?	O MEDICAL	HOSPITAL:		PLACE OF DEAT	OTHER									
1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify)															
1 Natural 5 Pending (Month, Day, Year) INJURY WORK?															
2 Accident investigation 28s PLACE OF INJURY — 41 home farm street factors office.															
4 Homicide determined Duilding, etc. (Specify) City or Town, State)									OF FIGURE F	todie transen,					
									\dashv						
298. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated, one) 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation in my coloring death occurred at the time, date and place, and due to the cause(s) and menner as stated, one)										2331					
2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner as an								afed.							
BE (296. SIGNATURE AND TITLE	OF CERTIFIER	1/4	ha	()		-	SIC LICE	HSE YUM	BEN 1		29d, DAT	T-SIGNED	Manor Out to	
	- K.	1/2/1	MIMO	IN A				11:	246	16		- /	41	2127	
- [30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	SE OF DEATH	(ITEM 27) (Type,	Print)		-							
	Robert L. G	attuso	MD - 1	6940	York Ro	l S	uite	204	В. н	lerefo	rd.	MD 21	1111		
	DEC 16 19	94 Ja	La d'avelle	R'S CRYALL	Dt,										

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,

Thomas

31. DATE FILED (Month, Day, Year)

		94 3/338	
		1 - STATE STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE	
		1 - REGISTRAR CERTIFICATE OF DEATH REG. NO.	
	1	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH	
	1	Jackson Daomi December 12/99 200	M
	1	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BURTH A BURTNEY ACE (State or Foreign	
	1 3	217-54-1863 1 DM 2 XF 63 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) Country)	
	1	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH	_
	Œ	2	I
	5	JOSEPH RICHIE HOSPICE BALTIMORE NIA	
	RECTO	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY	
		MARICAND N/A BALTIMORF 1 X YES 2 NO	
		10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?	
	ERAL	2202 TUCKER LANE, APT B.5 21207 USA.	
	FUN	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No.) 14. RACE - American Indian	_
		1 Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Cuben, Maxican, Puerto Rican, etc.) Black, Whita, etc.	
	В	3 Widowed 4 Divorced	
	B	15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY	
	ET	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.)	
	립	12+4 GRADE HOMEMAKER OWN HOME	
at once	COMPL	17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surname)	
	ЕС	CARVILL C. TURNER RUTH E. BARBOUR	
fled	00	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
notified	5	MICHAEL TUDIED CALLET STEEL COLORS	100
e		202, METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION / Name of DATE 20c. LOCATION — City or Town, State	4
must		1 Burlai 2 Cremation 3 Ramovat from Stata cemetery, crematory or other place)	
ler r		4 Donation S Other (Specify) WOODLAWN CEMETERY 12-16-14 BACTIMORE, MD, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY	_
examiner		JOSEPH H. BROWN JR. FUNERAL HOME	
ex.		1913 W. BALTIMORE ST., BALTIMORE, MD.2122	3
medical		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heert failure. List only one cause on each line.	
		IMMEDIATE CAUSE (Fine)	
or other traumatic event, the		disease or condition - Multiple metastoses in asdomen with 6 mon	. 10
New Sea		DUE TO (OR AS A CONSEQUENCE OF):	
ic e	z	Mixed mesodermal Isancoma of utences I year	
E	RTIFICATION	Sequentially list conditions, if any, leeding to immediate	
tra E	8	cause. Enter UNDERLYING	
the	E	CAUSE (Disease or injury that initieted events DUE TO (OR AS A CONSEQUENCE OF):	
6	E	reaulting In deeth) LAST	
2	O	BADT II Ohan Janifford and Aller and	
shows any injury,	EDICAL	PART ii. Other aignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PINDING AWAILABLE PRIOR TO	18
an	ă	1 TYES 2 NO COMPLETION OF CAUSE OF DEATH?	
MO.	ME	1 _ YES 2 _ NO	
23 st		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D	
item 2	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	
or ite	Sic	HOSPITAL: 1 YES 2 NO HOSPITAL: 1 Inpetiant 2 ER/Outpetiant 3 DOA 4 Nursing Name 5 Residence 6 No Other (Specify) Richey 1405 pice	
	РНҮ	27. MANNER OF DEATN 288. DATE OF INJURY (Month, Day, Year) 285. TIME OF INJURY AT WORK? 286. DESCRIBE HOW INJURY OCCURED INJURY	\neg
marked,	BY	1 Natural 5 Pending 2 Accident Investigation M 1 YES 2 NO	
is E		3 Suicide a Could not be 28e. PLACE OF INJURY — At home, tarm, street, factory, office 26i. LOCATION (Street and Number or Rural Route Number,	
28	ш	4 Homicide datarmined building, atc. (Specify)	
item	PLET	29a. CERTIFIER (Check only Ch	
V 355	Σ	(Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(a) and manner as stated. MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(a) and manner as stated.	
IMPORTANT:	8		
PO	BE	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)	
W	0	M.D. D13006 13 Dec 94	
	-	30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)	

Read

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Baltimone

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DHMH-16 Rev 1/89

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FOR 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

		REGISTRAR		CE	:RUIFI	CALE	T DEATH	REG. NO				
		1. DECEDENT'S NAME (First, Middle, Last)	_					2. DATE OF DEATH MONTH DA	AY	YEAR 525	TH 4	
		MILDRED VIRGINIA 4. SOCIAL SECURITY NUMBER			hten de a			DEC 1	5	74 500	Ам	
		217-22-8000	1 M 2 F	6. AGE (In yrs. lest	YRS.	MONTHS DAY		7. DATE OF BIRTH (Month, Day, Year)		L BIRTHPLACE (State or Fi	oreign	
pinous		90. FACILITY NAME (If not institution, give st		01		9b. CITY, TOV	VN OR LOCATION OF DE	March 5,19		Maryland TY OF DEATH		
2, 3 Se	NO B	Stella Maris Hosp	oice			Tow	son	Baltimore				
- -	ای	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c CITY	r. TOWN OR LO						
Pages	DIRECTOR	Maryland					ore City			10d. INSIDE CITY LIMITS? 1 X YES 2		
permit.		10e. STREET AND NUMBER				Dai oill	101. ZIP CODE		10g. CITIZE	EN OF WHAT COUNTRY?	NO	
. Ist	IERAL	5106 Plymouth Ro	1.				21214		U.5	S.A.		
215-0020 attending physician. se as the burial-transit	FUN	11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT FORCES? 1	EVER IN U.S. ARI	MED O	13. WAS	DECENDENT OF HISPAI , specify Cuban, Maxica	NIC ORIGIN? (Specify Yes		4. RACE — American Indi Black, White, atc.	len,	
5-0020 nding physic as the burial	Β¥	3 Widowed 4 Olvorced	IF YES, GIVE WA	AR OR DATES			YES 2 X NO Specif			Specify: White		
r attend	ED	15. DECEDENT'S EDUC (Specify only highest grade		16a. DEC	CEDENT'S	USUAL OCCUP	ATION	16b. KINO OF BUS	SINESS/INDU	STRY		
21 al or for u	COMPLET	Elementery/Secondary (0-12) College (1-4 or 5+)			Do NOT us	e retired.)	most of working					
ND hospit ached	MP	12 yr's			Homemaker			Own Home				
YLAND 2. by the hospital of the detached for all once.		17. FATHER'S NAME (First, Middle, Last) John S.	Hook				I _	ME (First, Middle, Meiden	Surname)	Cohmoleon		
	B	John S. 190. INFORMANT'S NAME (Type/Print)	Heck	T 196	MAILING	AOORESS (Stre	Rose	May Route Number, City or Tow.	n State 7in C	Schmalzer		
MAR e retained e 5 should notified	임	Mr. Edward W. O'L	oughlin					Fallston		21047		
BALTIMORE, after death. Page 6 may be y the funeral director, page moval.		20a. METHOD OF DISPOSITION 1 Burlal 2 □ Cremation 3 □ Rame			NDDATEO	F DISPOSITION				ty or Town, State		
BALTIMORI ter death. Page 6 may the funeral director, p wal.		4 Donation 5 Other (Specify)	-	cemetery, cren	'KWOO	d Cem.	December	19,1994	Baltim	nore, MD		
ALTIN death. Pag tuneral dir i.	1	21. SIGNATURE OF FUNERAL SEMMICE LIC	/ - D	1		22. NAMI	E AND AGORESS OF FA	Baltime	ore, M	1D 21214		
BAI Fer dea		Leonard J. Ruck. Inc. 5305 Harford Rd. 23. PART I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
in b		23. PART I. Enter the diseeses, or of ahock, or heart failure.	complications that List only one caus	caused the dec	eth. Do n	ot enter the	mode of dying, suc	h ss cardiac or respi	ratory arres	st, Approxim		
E 9 ⊞		IMMEDIATE CAUSE (Finel disease or condition	0.1		da	a . 1	dia			Onset an		
F age -		resulting in death)	a. Chas	OR AS A CONSEQ	A GO	act-	discos	e		40	ر خ	
N 8 5 = 6	2			on no n consta	OLIVOL OF)·				0		
8 0 F	CERTIFICATION	Sequentielly list conditions, if sny, leading to immediate	DUE TO (OR AS A CONSEO	UENCE OF):						
m # \$ = =	S	cause. Enter UNDERLYING CAUSE (Disease or injury										
		that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST										
# 5 m	E E		1								-	
	¥.	PART II. Other significant condition	s contributing to d	death but not re	suiting i	n the underl	ying ceuse given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY F AVAILABLE PRIOR		
COR uires that signed by Health and	EDICAL	_A103						1 _ YES 2	NO	COMPLETION OF OF DEATH?	CAUSE	
		DID TORACCO LISE	CONTRIBUTE	TO CALIS	E OF	DEATH	VEC CO NC	777		1 🗌 YES 2 🗍	NO	
AL RE e law reque has been Dept. of H	AN	DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE	TO CAUS	OF OF		YES NO			<u> </u>		
N: Th N: Th icate State	SICIAN: M	EXAMINER?	HOSPITAL:	ER/Outpatient 3	DOA	OTHER:	Homa 5 - Residence		Hogpi			
YSICIA YSICIA S certif th the	PHY	27. MANNER OF DEATH	28a. DATE OF I (Month, Day	INJURY	28b. TIME	E OF 26c.	INJURY AT	28d. DESCRIBE HOW II	Hospi			
ON OR DING PHYS After this death with	BY F	1 Natural 5 Pending 2 Accident Investigation	(Month, Da)	y, rear)	INJU		WORK?					
DIVISION OR ATTENDING F DIRECTOR: After hours after death tem 28 is mar	ED	3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF building, a	INJURY — AI hon	ne, lerm, si	treet, lactory, o	offica	281. LOCATION (Street a City or Town, State)	ON (Street and Number or Rural Route Number, own, State)			
DIVISI OR ATTEN DIRECTOR: hours after Item 28 is		AL ACTION N										
4 7 P =	COMPLET							to the cause(s) and men				
THE HOSPITAL THE CHASERAL fined within 72 ONTANT: III	Ş	2 MEDICAL EXAMINE		amination and/or in	rvestigation	n, in my opinio			d due to the	cause(e) end manner ae s	stated.	
TO THE HOSPITE TO THE CUREFA Fixed within 7	A	296;SIGNATURE AND TITLE OF CERTIFIER	OF	2010 DA	1101	1011	29c. LICENSE NUI	WBER	29d. DATE :	SIGNED (Month, Day, Year)		
P 4	9	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSI	E OF OEATH (ITEM	27) (Type.	Print)	7-000	70	- 10	113/94		
		DR. KENDALL FAU	LKNER 2	2300 DIII.			Y RD., TOV	WSON, MD 2	21204			
		31. DATE FILED (Mogth, Day, Year)	A PREGETBAR	A CHATTE				,				
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THE HEST LOW ATTENDING PHYSICIAN: THE TAW TEQUIES THAT THE GEATT CERTIFICATE OF EXECUTED WITHIN 24 DOURS ARE DESTRUCTED.	TO THE ENTERINAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	8	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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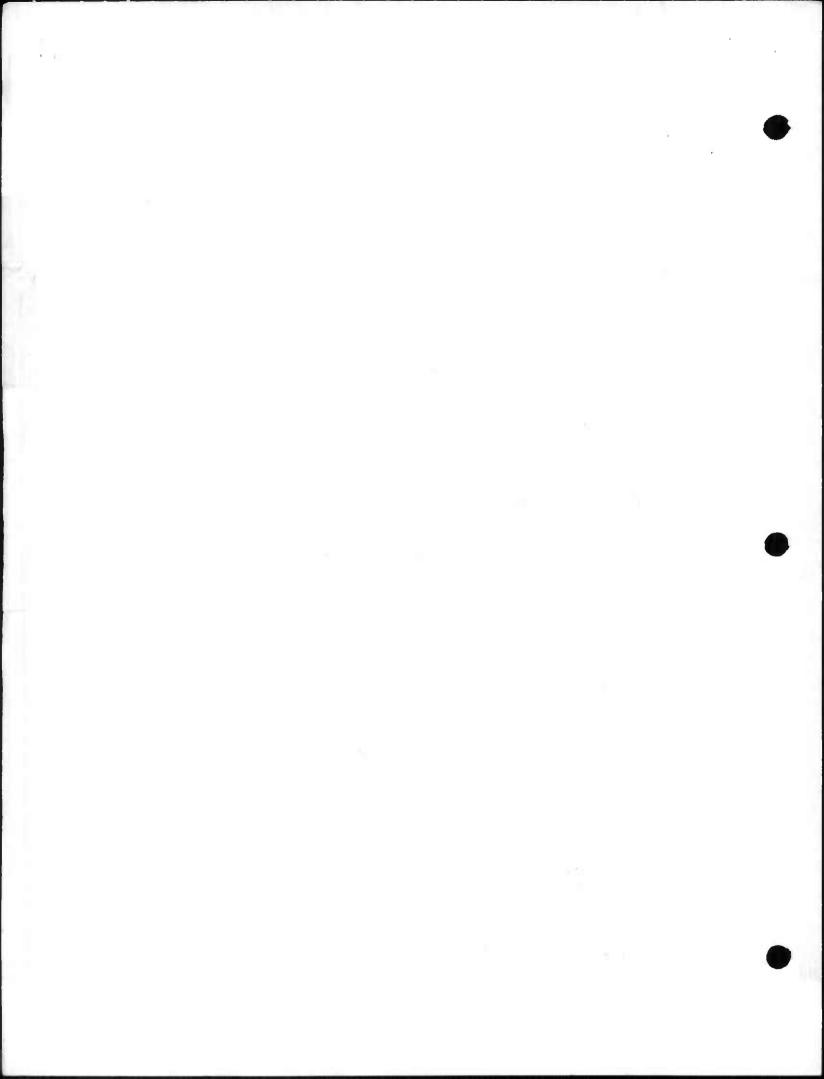
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF CEATH DOR Ar 0 RN WIL 1994 9:10 Dec. 12 DM 7. DATE OF BIRTH (Month. Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign Country) HOURS 1 X M 2 | F YRS 204-05-0641 97 Jan. 8. 1897 Pennsylvania 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Levindale Geriatric Center Baltimore Baltimore RESIDENCE OF DECEDENT 10a STATE 10h COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Maryland Pikesville 1 YES 2 K NO 104. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1211 Glenback Avenue 21208 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married It yes, specify Cuban, Maxican, Puarto Rican, etc.) FORCES? 1 12 YES 2
IF YES, GIVE WAR OR DATES 1 YES ZX NO Specify: B⊀ Specify: 3 🔯 Widowed 4 🗌 Divorced W.W.I White 16a. DECEDENT'S USUAL OCCUPATION

Third of work done during most of working ETED. 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compl (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 6th Self-Employed Carpenter 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) William Orndorff Regina Smith BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Mrs. Susan Algire 7287 Swan Point Way Columbia, MD 20a. METHOD OF DISPOSITION
1 Disposition | 1 Ramoval from State | 4 Donation | 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION — City or Town, State Prospect Hill Cemetery 12/15 York, Pennsylvania 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. amos 8728 Liberty Road Randallstown,MD 21133 23. PART Lefter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, hock, or heart failure. List only one cause on each line interval Retween IMMEDIATE CAUSE (Final **Onset and Death** disease or condition_ SP reaulting in desth) OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantisily ilst conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated aventa CANCER resulting in death) LAST UNG PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL DEMENTA & CONGESTIVE HEART NO DF DEATH? FRILLURE : 4460LH1601D17W 1 | YES 2 | DID TOBACCO USE CONTRIBUTE TO CAÚSE OF DEATH YES IN NO INCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER:
Nursing Home 5 - Residence 8 - Other (Specify) 1 YES 2 NO Inpetient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 1 YES 2 HO BY nveatigation 28a. PLACE OF INJURY — At home, tarm, atreet, factory, offica 281, LOCATION (Street and Number or Bural Boute Number 3 Sulcide COMPLETED 8 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the mination and/or investigation, in my opinion, death occured at the time, data and placa, and dua to the cause(a) and mannar as stated. 296. SIGNATURE AND TITLE OF CERTIFIE 29c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE 0 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760,	SEPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate he executed within 24 hours of
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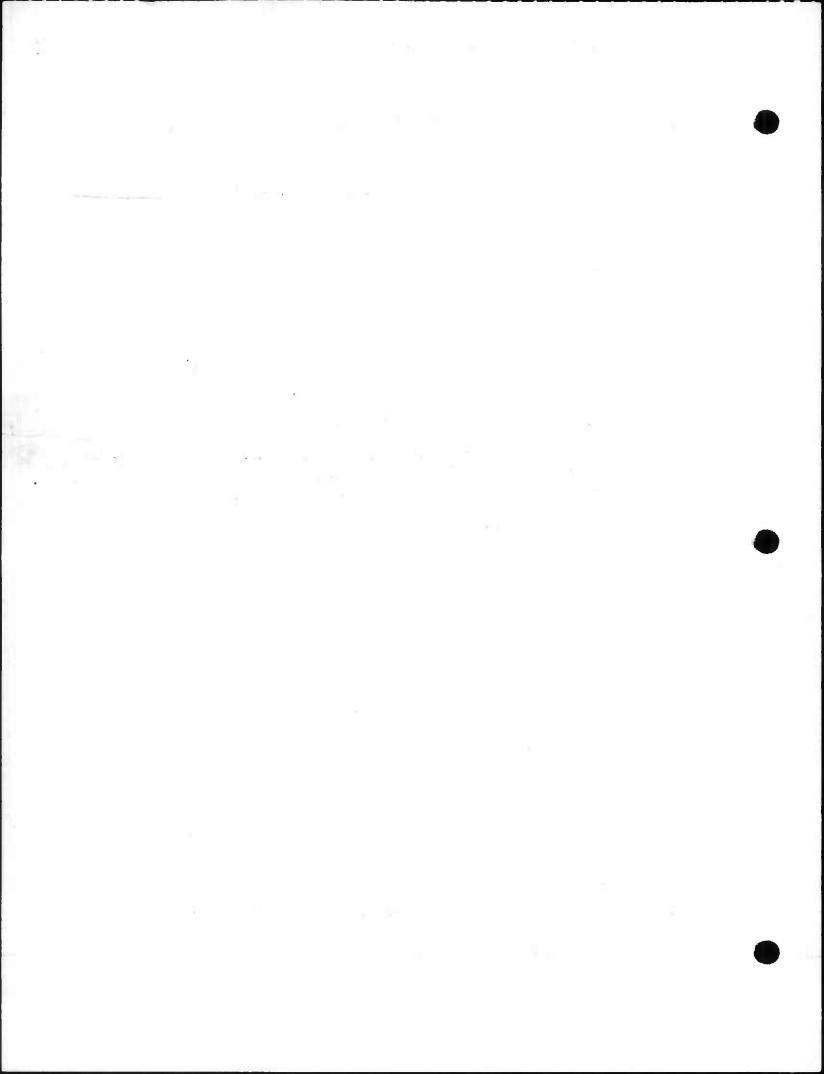
1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 12 06 3. TIME OF DEATH Frances Hagen POWELL 1994 06 8:00P M 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH BIRTHPLACE (State or Foreign Country) HOURS 216 46 3923 1 M 2 X F 101 YRS. 7-11-1893 Minnesota use as the burial-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Pickersgill Retirement Comm Towson Baltimore Co 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore Co Towson 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 615 Chestnut Avenue 21204 USA after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 TO NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: RACE — American Indian, Black, White, etc. 1 Never Married 2 Married ВҰ Specify: 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high the funeral director, page 5 should be detached for Elementary/Secondary (0-12) College (1-4 or 5+) 12+ War Department Homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John Conrad notified at Hagen Mary Obely 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Wood FairwayWinds Pl, Hilton Head, SC 29928 pe 20a. METHOD OF DISPOSITION
1 Guriel 2 Gremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION -- City or Town, State OATE must 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSÉE Ronald examiner Wade, Dir 22. NAME AND ADDRESS OF FACILITYS tate Anatomy Board 655W.Baltimore St,Balto,MD21201 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, filled in by shock, or heart failure. List only one cause on each line 10 Interval Between IMMEDIATE CAUSE (Final Onset and Death and completely fille burial, cremation, the Aspiratin previousia
oue to (or as a consequence of): disease or condition 3 hou resulting in desth) event, Multiple Cerebro Viscula Acadest DUE TO (OR AS A CONSEQUENCE OF): traumatic MEDICAL CERTIFICATION Sequentisity list conditions, Hygiene prior to If any, leeding to immediate cause. Enter UNDERLYING other t CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 the atten 23 shows any injury, PART II. Other aignificant conditions contributing to death but not resulting in the undariying cause given in Pert I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO signed the COMPLETION OF CAUSE 1 YES 2 THO 1 | YES 2 | NO PHYSICIAN: has be Dept. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) certificate h **EXAMINER?** HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA e 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED is marked, this (1 Natural 5 Pending Investigation 1 YES 2 NO After t BY 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 8 Could not be FUNERAL DIRECTOR: within 72 hours after item 28 4 Homicide 29a. CERTIFIER
(Chack only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(a) and menner as stated. COMPLE MPORTANT: II 2 MEDICAL EXAMINER; On the basic of examplesion end/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(a) and menner as stated. BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Ybar) THE 02520 12/07/98 223 5 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Sps. Print) ANTHONY RILEY 32. PRGISTRAR'S SIGNATURE
Java Davilson Randall



		FOR STATE REGISTRAR	STATE OF MARYLA	ARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
, 2, 3 should	120	1. DECEDENT'S NAME (First, Middle, Lest)	ANNAY	Piquett	2. DATE MONT	OF DEATH	2 19	(EAR)	30 PM			
		4. SOCIAL SECURITY NUMBER 21720445	5. SEX 8. AGE (In		THE DAYS	IF UNDER 24 HRS. HOURS MIN.		OF BIRTH h, Day, Year) 4 - 20		BIRTHPLA Country) Virg:	CE (State or Foreign	
	стов	BE. FACILITY NAME (If not institution, give s FRANKLIN SQUAR RESIDENCE OF DECEDENT		OR LOCATION OF DEATH ROSSVIII				Baltimore Rossville				
it. Pages 1,	DIREC	10a. STATE 10b. COUNTY	Baltimore	10c. CITY, TO	WN OR LOCA		unda	lk			. INSIDE CITY LIMITS?	
020 physician. burial-transit permit. Pages	IERAL	100. STREET AND NUMBER 8305 Kavanagh I	Road		10	I. ZIP CODE	222		10g. CITIZE		country? States	
9 a e	BY FUN	11. MARITAL STATUS 1 Never Married 2 Narried 3 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 XNO	If yes, sp	CENDENT OF HISPA Decity Cuban, Maxic S 25 NO Speci	an, Puerto				American Indian	
2 2 2	ETED	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5 +)	18a. DECEDENT'S USUA (Give kind of work of life. Do NOT use retir	done durina me	ON ost of working	168	. KIND OF BUS	SINESS/INDUS	TRY		
MARYLAND 2 retained by the hospital 5 should be detached for notified at once.	COMPL	8 Years 17. FATHER'S NAME (First, Middle, Last)	Housewife			18. MOTHER'S NAME (First, Middle, Meid				n Home		
2 2 2 E	BE C	Theodore Brooks			Lottie Brooks							
MAR e retained to 5 should notified	2	194. INFORMANT'S NAME (Type/Print) Sharon A. Easte	er			end Number or Rurel rail Way		ber, City or Tow Ltimor		2123	84	
IMORE, Page 6 may be I director, page		20a. METHOD OF DISPOSITION	20b. F	PLACE AND DATE OF DIS	SPOSITION (N	arije of	DAT	F 20c LO	CATION - CIT	v or Town	State	
IMO Page 6 directs		4 Donation 5 Other (Specify)	1 S	tery, cremetory or other pi	of Je	SUS Cem.	12/1	5/94	Dundal	k, M)	
SALT death. le funera		· (hal h	- Fish		Dud 792	a-Ruck F 2 Wise A	unera ve.	Dunda	lk. Ma	rvlar		
in t			omplications that caused List only one cause on as	tha death. Do not a ch lina.	nter tha mo	da of dying, suc	ch as can	diac or reapi	ratory arres	t, [Approximate interval Between	
ithe		IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO (OR AS A C	CONSEQUENCE OF):	ej ri	xncer	_				Onset and Death 2 years	
atte	TION	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A C	CONSEQUENCE OF):								
ficat phy ine p	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):									
S, P death atten ental H		2021	1							1		
y and at	EDICAL	PART II. Other significant condition	a contributing to death but	t not reaulting in the	e undariyin	g cause given in	Part I.	24s. WAS AN PERFOR	MED?	AWAI	E AUTOPSY FINDINGS LABLE PRIOR TO IPLETION OF CAUSE DEATH?	
- D -:	. M	DID TOBACCO USE CONTE	RIBUTE TO CAUSE OF	DEATH YES	NO E	UNCERTAI	N []	-		1 [YES 2 HO	
VITAL I	PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	B. PLACE OF DEATH (C)	heck only one) HER:							
SICIAN: The certificate in the State d, or item	HYS	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME OF	28c. INJ	IURY AT	_	(Specify) CRIBE HOW II	NJURY OCCUP	RED		
ON OF DING PHYSI After this of death with	ВУ Р	Natural 5 Pending Investigation	(Month, Day, Year)		M 1 🗆							
TISIC NTTENDI CTOR: A after d after d		3 Suicide 8 Could not be datermined	28s. PLACE OF INJURY - building, etc. (Specify	At homa, ferm, atreef,	n, atreef, factory, office 28			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
로 그 이 누	COMPLETED		CIAN: To the best of my knowled R: On the basis of examination a							ause(s) and	manner as stated,	
TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If	TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	ey MI)			RD 1786			29d. DATE S ▶ /2	IGNED (Mon	th, Day, Year)	
	-	Dr. Amanda Trimpe	completed cause of Deat y 9000 Frank	TH (ITEM 27) (Type, Print) lin Square	Dr.	Baltimor	e,Ma	ryland	21237	-		
		31. DATE FILED (Month, Day, Year) DEC 16 100	32. REGISTRAR'S SIGNAT	LOD ROLL								

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THE HUSHIM. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-hours after death. Page 6 may be retained by the hospital or attending physician.

THE HUSHIM. DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be marked at the second at the second at the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.

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_		FOR 1 - STATE REGISTRAR	STATE OF N	MARYLAND /	DEPAR					MENTAL	HYGIEN REG. NO.	_			
		1. DECEDENT'S NAME (First, Middle, Last)	Joseph	Joseph Leo Palmerino, III						MONTH	OF OEATN	NY.	YEAR 3. TIM	ME OF DEATH	
			3. SEX				R 1 YEAR	IF UNDER	24 HRS. MIN.	7. DATE ((Month)	DATE OF BIRTH 8. ((Month, Day, Year)		8. BIRTHPLACE Country)	(State or Foreign	
		218-84-6278 1 9a. FACILITY NAME (If not institution, give stree	21	25	YRS.	9b. CITY, TOWN O		OR LOCATE	ON OF DE		22/196		Maryl TY OF DEATH	and	
- 1	Œ	Johns Hopkins Bay										SC. COOK	TIT OF DEATH		
	6	RESIDENCE OF DECEDENT	iew medical Ctr.				Baltimore City					L			
	DIRECTOR	10a. STATE 10b. COUNTY		10c. CIT	CITY, TOWN OR LOCATION								NSIDE CITY		
			altimore	ltimore				Dundalk				1 _ YES 2			
	3AL	10e. STREET AND NUMBER					10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTR			OUNTRY?	
- 1	NER	7816 Saint Bonifa							2122				ited St	ates	
	FUN	11. MARITAL STATUS 1 Never Married 2 Married	FORCES? 1	TEVER IN U.S. ARI	MED 40-	13.		ENDENT O			(Specify Yearcan, etc.)	or No-	14. RACE — Am Black, White	erican Indian, a, alc.	
	ΒX	3 Widowed 4 Divorced	IF YES, GIVE W	WAR OR DATES			1 TYES	2 NO	Specify:			1	Specify:		
	a	15. DECEDENT'S EDUCAT	'ION	16a. DE	CEDENT'S	USUAL C	CCUPATIO	ON		16b.	KIND OF BUS	SINESS/IND	White		
		(Specify only highest grade cor	mpleted) College (1-4 or 5 d	(Gi	ive kind of a	work done se retired.)	during mo	sl of working	ng .						
	릴	12 Years			ales	es Manager					Retai	1 (1)	othing		
once.	COMPL	17. FATHER'S NAME (First, Middle, Last)						NER'S NAM	ME (First, M	liddle, Maiden		/Lumg_			
3	BE (Joseph Leo Palmer	ino. Jr	c				Je	eanet	tte F	Bifano				
E I	0	19a INFORMANT'S NAME /Appa/Print							and Number or Rural Route Number, City or Town, State, Zip Code)						
be notified at	۴	Jeanette Zechman		7816 Saint Bonif						face Lane Dundalk. MD 21222					
		20e, METNOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, Slate											eta /		
Ē		4 Donation & Other (Specify) Hillton Service Corp. 12/16/94 Towson, Maryland													
examiner must		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Duda—Ruck Funeral Home of Dundalk, Inc.													
еха		7922 Wise Ave Du									Indal	undalk MD 21222			
medical		23. PART I/Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate													
E	}	IMMEDIATE CAUSE (Final Oppet and Death													
it, the	}	disease or condition											7mos		
event,			OUE TO	DUE TO (OR AS A CONSEQUENCE OF):										G	
	S	Sequentially list conditions.											1 mos		
traumatic	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): oue TO (OR AS A CONSEQUENCE OF):														
other t	잂	CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):													
010		resulting in death) LAST											!		
injury,	ວ ∥	DART II Other significant conditions of											+		
y in	EDICAL	PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i.								24a. WAS AN PERFOR		AVAILA	AUTOPSY FINDINGS ABLE PRIOR TO		
rs any		111101119								- !	1 YES 2	100	DF DE	LETION OF CAUSE ATH?	
shows	Σ∥	DID TOP ACCOUNT CONTRIB	VIITE TO 64	1105 05 050				1		[1 🗆 1	YES 2 NO	
23	Ä	DID TOBACCO USE CONTRIB	UIE TO CA		TH YE			UNC	ERTAIN						
Hem	SICI	EXAMINER?	IOSPITAL:			OTHE	R:								
9	⋛∦	27. MANNER OF DEATN							lome 5 ☐ Rasidence 8 ☐ Other (Specify) INJURY AT 28d, DESCRIBE HOW			IN HIDY OCCUPED			
9	۵ ا	1 Natural 5 Pending	lay, Year)	INJ	IURY M	WO	RK?	NO		I. DESCRIBE HOW INJURY OCCURED					
	₽ BY	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE O	F INJURY — At hor	me, larm, r	street, lac	tory, office						umber,		
28	ETE	4 Homicide determined	bullding,	etc. (Specify)						City o	r Town, State)				
	2	29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of	my knowledge, de	ath occum	ed at the	tima, data	and place.	end dua l	In the caus	se(e) end man	ner se state	wd.		
S	OM	one) 2 MEOICAL EXAMINER: (nanner ae stated.	
RIA	2	29b. SIGNATUNE AND TIPLE OF CARDIFIER	/ · · · · · · · · · · · · · · · · · · ·					-	NSE NUM				SIGNED (Month		
2	8	JUISIN V	MA							398		DATE DATE	12-13	0.1	
-	2	30, NAME AND ADDRESS OF PERSON WHO C	OMBI ETED CALL	CE OF DEATH (ITEL	M ATD (E	On/orth		V	100	210		/	12-15	- / /	

N. Wolfest,

Sallant MD 32. REGISTRAR'S SIGNATURE Julia Dawolson Randall

31. DATU FILEO (Month, Day, Year)

Baltimere Baltimere

Carnegie 292

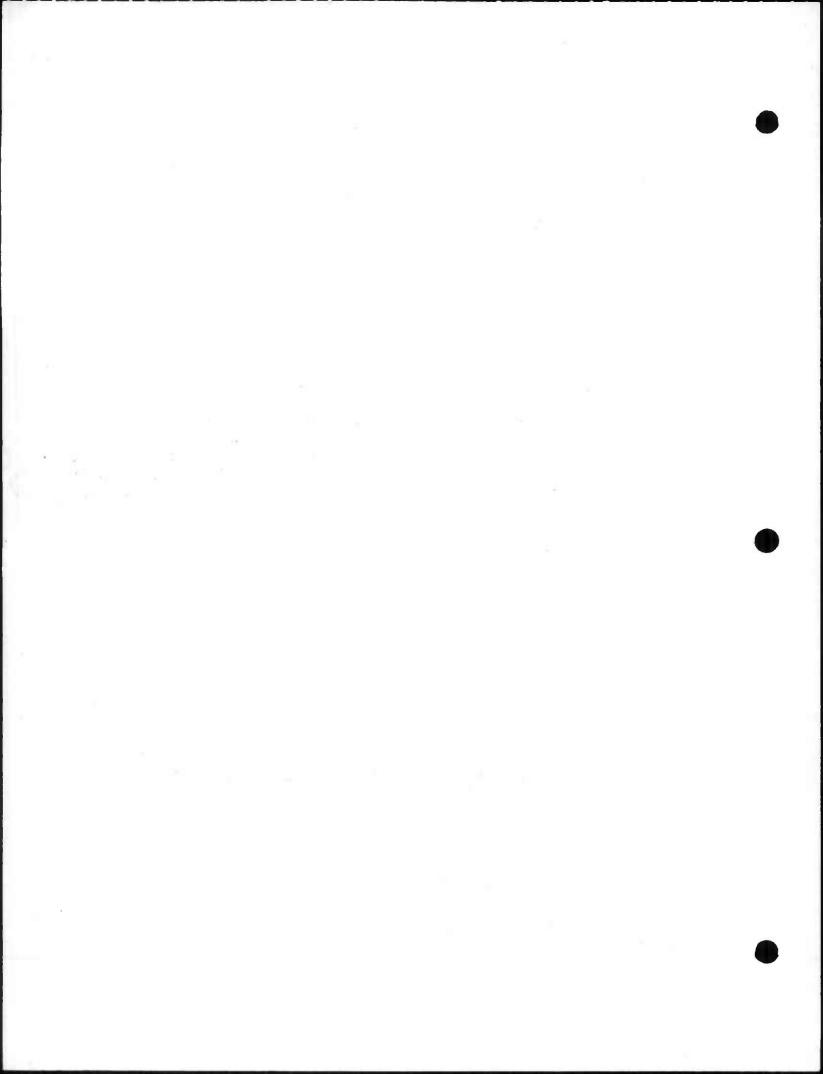
BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nouns after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

							1	4 01047			
	1 - FOR STATE REGISTRAR	STATE OF MARYLAND /	DEPARTM ERTIFICA			MENTAL HYGIEN	_				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH			
	DONOVAN		PAR	KER		DEC		94 2:59 P.M			
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. lest	t birthday) IF	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8.	BIRTHPLACE (State or Foreign			
	216-78-5079	12□ M 2 □ F 33	faryland								
	9a. FACILITY NAME (If not institution, give stree	et end number)	96.	CITY, TOWN	OR LOCATION OF D		9c. COUNTY				
Œ	400 C ADDICON	c.m					N/A				
읝	400 S.ADDISON S	51.	<u> </u>	SALTI	MORE CI	Т. Х	11/11				
DIRECTOR	Maryland N/A			WN OR LOCA			10d. INSIDE CITY LIMITS?				
			Bal	timor				1 X YES 2 NO			
FUNERAL	100. STREET AND NUMBER 2526 Frederick	Avenue		10	21223		10g. CITIZEN US	OF WHAT COUNTRY?			
5		12. WAS DECEDENT EVER IN U.S. ARI		13. WAS DEC	ENOENT OF HISPAI	NIC ORIGIN? (Specify Yes	or No.— 14.	. RACE — American Indian,			
BY	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 TYES 2 XN IF YES, GIVE WAR OR OATES	10		ecity Cuben, Maxica 2 X NO Specif	n, Puerto Rican, etc.)		Specify: Black			
	15. DECEDENT'S EDUCAT (Specify only highest grade co.		CEDENT'S USU	AL OCCUPATION	ON	16b. KIND OF BUS	SINESS/INDUS	TRY			
Ψ,	Elementary/Secondary (0-12)		Do NOT use ret	ired.)	st or working						
P P	10th grade		Labor	er							
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle, Melden	Surname)				
BE C	Milton Parker				Carol	yn M. Jo	nes				
	19e. INFORMANT'S NAME (Type/Print)	19b	. MAILING AOC	RESS (Street a	and Number or Rural:	Route Number, City or Tow	n, State, Zip Co	de) 21216			
임	Carolyn M. Park	er 22	406 G	arris	on Boul	evard Ba	1timo	re, Maryland			
- 1	200. METHOD OF DISPOSITION		NODATEOFO		me of	DATE, 20c. LO	CATION — City	or Town, State			
	X☐ Burlel 2 ☐ Cremetion 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)		zion (lace)	erv	.2/8/94 ₈₃₁	timor	e, Maryland			
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	21011	22. NAME AI	ID ADDRESS OF FA	CILITY 5240	Poict	erstown Rd			
	Nounds.	rris					V612C	more, Md212			
-											
	23. PART I. Entar the disesses, or cor shock, or heart fallure. Lis	mplications that caused the dat at only one cause on each line.	sth. Do not a	ntar the mo	da of dying, suc	h aa csrdiac or reapi	ratory arrest	Approximate Interval Between			
	IMMEDIATE CAUSE (Final										
	disease or condition - a. Multiple Blunt and Sharp Force Injuries DUE TO (OH AS A CONSCOUENCE OF):										
1	DUE TO (OR AS A CONSEQUENCE OF):										
Z	Sequentially list conditions, b. Our vo con as a consequence or										
CERTIFICATION	If any, leading to immediate	DUE TO (OR AS A CONSEO	UENCE OF):								
2	CAUSE (Disease or Injury										
#	that initiated eventa resulting in death) LAST	OUE TO (OR AS A CONSEO	UENCE OF):								
H	d										
	PART II. Other significant conditions of	contributing to death but not a	equiting in th	o Underbilo	a course alves la	Special Consumption	AL COORDAY				
8		To the state of th	acutting in the	ondenym	d canae diveil iii	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO			
ă						1 X YES 2	□ NO	OF DEATH?			
X						_ '		1 YES 2 NO			
ÿ	DID TOBACCO USE CONTRIE	BUTE TO CAUSE OF DEAT	TH YES [UNCERTAIL	V 🗆					
3	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACI	E OF DEATH (C	heck only one)							
IS		☐ Inpatient 2 ☐ ER/Outpatient 3			e 5 🗆 Residence	6 X Other (Specify)	ANCAN	NT LOT			
PHYSICIAN: MEDICAL	27. MANNER OF OEATH	28e. OATE OF INJURY (Month, Pay, Year)	28b. TIME OF	28c. tNJ WO	URY AT	subject beat					
ВУ	1 Natural 5 Pending 2 Accident Investigation	Found 2-94	1459 D	M 1 🗆		subject beat	ren, cut,	STADDER			
	3 Suicide 6 Could not be	28s. PLACE OF INJURY — At hor building, etc. (Specify)	ne, farm, atreet	, factory, offic		281. LOCATION (Street a	and Number or I	Pural Poute Number, ock Addison St			
COMPLETED	4 Homicide determined	Found in vac	ant le	st-		Baltima	4000	D Radison of			
ا ت	29a. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my knowledge, des	th occurred at	the time date	end place, and due	to the cause(s) and	mer se stated	*			
ž		On the besis of examination and/or in						euse(s) and manner as stated			
				,							
BE	29b. SIGNATURE AND TITLE OF CERTIFIER	0111	110		29c. LICENSE NUI			IGNED (Month, Day, Year)			
2	30. NAME AND ADDRESS OF PERSON WHO'S	1 mute	19		O.C.M	.E.	DEC	3,1994			

111

Penn Street, Baltimore, Maryland 21201



TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687604

1 - FOR STATE REGISTRAR

	REGISTRAR		CERTI	FICATE (OF DEA	ин		REG. NO		
	1. OECEOENT'S NAME (First, Middle, Last)							OF DEATH		3. TIME OF DEATH
	CHESTER POPE						DECE		13 199	
	4 SOCIAL SECURITY HUMBER	5. SEX 6. AGE	(In yrs. last birthde)) IF UNDER 1 Y	AR IF UND	ER 24 HRS.	7. DATE	OF BIRTH	8. B	HRTHPLACE (State or Foreign
	200-10-0873	1 M 2 X F 4	14 YRS.	MONTHS D	NYS HOURS	MIN.		h, Day, Year) 9-50	C	ountry)
	9a. FACILITY NAME (If not institution, give s	treet and number)		9b. CITY, TO	WN OR LOCAT	TION OF D		9-30	9c. COUNTY (alto. Md
Œ	THE TOUNG HODIET	NC HOCDITAL							SC. COONTY	A DEATH
16	THE JOHNS HOPKI	NZ HOZPITAL		I BAL	IMORE	CITY	<u>/</u>			
DIRECTOR	10a. STATE 10b. COUNTY	r	10c. C	ITY, TOWN OR L	OCATION					10d. INSIDE CITY
1 8	MD			Baltimore						LIMITS?
1	10e. STREET AND NUMBER			Daloi	10f. ZIP CO	DE			100 CITIZEN	OF WHAT COUNTRY?
8	1503 W. Mosh	er St.			7	121	10			
FUNERAL	11. MARITAL STATUS				oc.	1 501	<u> </u>		USZ	
교	1 Never Married 2 Married	12. WAS DECEDENT EVER I FORCES? 1 YES	2 NO		e, specify Cub			? (Specify Yes Rican, etc.)	or No — 14. F	RACE — American Indian, Black, White, etc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAR OR D	DATES	1 🗆	YES NO	Specif	y:		5	Specify:
	15. OECEDENT'S EDUC	CATION	Luc occeptur	10 1101141 0001			T			Black
COMPLETED	(Specify only highest grade	completed)	(Give kind o	'S USUAL OCCU of work done during use retired.)	g most of work	king	166	. KIND OF BUS	SINESS/INDUSTR	łY .
ا يّا ا	Elementary/Secondary (0-12)	College (1-4 or 5+)	75/2016		T-b		- {		Tobo	
Σ	12th		Unsk	illed				odd d		
8	17. FATHER'S NAME (First, Middle, Last)							Middle, Maiden		
B	Chester Patto	on						e Pop	•	
2	19a. INFORMANT'S NAME (Type/Print)								n, Stete, Zip Code	
-	Louise Levis		330	03 Win	dsor	Blv	d. E	Balto	. Md.	21207
	20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rame	oval from State	b. PLACE AND DAT	E OF DISPOSITIO	N (Name of		OATI		CATION — City of	
	4 Donation 5 Other (Specify)	W	estern	Star	Cen.	12	/17/	'94 Ba	alto.	Md.
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			E AND ADDR				20 mm = 10.	
	> JOHN (1 1)1107								RAL HOME, IN
\vdash	22 PADY I Serve the discuss of	1 1 / 1		460	O Lil	bert	y Ho	hts 1	Ave. B	Approximete
	23. PART I. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart fellurs. List only one cause on each line.									
1 1	IMMEDIATE CAUSE (Final									Interval Between Onset and Death
	disease or condition resulting in death)								5 days	
1 1		DUE TO (OR AS	A CONSEQUENCE	OF):						13
z		monun	I	Ja-fr	cier	an		untanum		
음	Sequentially list conditions, It any, leading to immediate	OUE TO (OR AS	A CONSEQUENCE	OF):			,	1		34.4.0007
8	cause. Enter UNDERLYING CAUSE (Disease or Injury	с.								
ᄪ	that initiated eventa	DUE TO (OR AS	A CONSEQUENCE	OF):						
CERTIFICATION	reauiting in death) LAST	d								
	DART II Other electrons are not			William !			-			
EDICAL	PART ii. Other eignificent condition		Dut not reauiting	In the under	lying ceuse	given in	Part I.	24a, WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ᆲ	Kenal fai	lure						1 TYES 2	□ NO	COMPLETION OF CAUSE OF DEATH?
ME										1 TYES 2 NO
1.0	DID TOBACCO USE CONTI	RIBUTE TO CAUSE C	OF DEATH	ES NO	DY UN	CERTAII	NO			
SICIAN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DE							
Sic	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 X Inpetient 2 ER/Out	petient 3 DOA	OTHER:	Home 5 🗆 F	b-ald	0 D Oth-			
PHY	27. MANNER OF CEATH	28a. DATE OF INJURY			INJURY AT	tesidence			NJURY OCCURE	0
	1 🔀 Netural 5 🗌 Pending	(Month, Day, Year)	200	NJURY	WORK?	Пио	200.020	CHIDE HOW I	NOON! OCCORE	1
B	2 Accident Investigation	28e. PLACE OF INJURY	V — At home form				204 1 00	ATADAL (D.		
8	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Spe	ecify)	, arrest, ractory.	ornee			or Town, State)	ind Number or Ru	ural Route Number,
<u> </u>								_		
필		CIAN: To the best of my know								
COMPL	2 MEDICAL EXAMINE	R: On the beals of examination	on and/or Investigat	tion, in my opini	on, death occu	ured at the	time, deta	and place, an	d due to the cau	se(a) and manner as stated.
ш	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LIC	CENSE NUI	MBER _		29d. DATE SIG	NED (Month, Day, Year)
00	Korkum 1	Wagnes	mi	\mathcal{L}		110	26		D 12/	13/94
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DE	EATH (ITEM 27) (Tyr	oe, Print)			VIN			9//7
	Kathryn Wagn	=		swar,	Talu	1c Ll	ant w	× 11-	Ja 1	12 110 AN
	31. DATE FILED (Month, Day, Year)	1 32. REGISTRAR'S SIGN	NATURE	, read	3 0/14	37	op - IV	2 1705	DITO!	Battamore MD
/ III	1 C 1004	Listenden-Ra	while .							

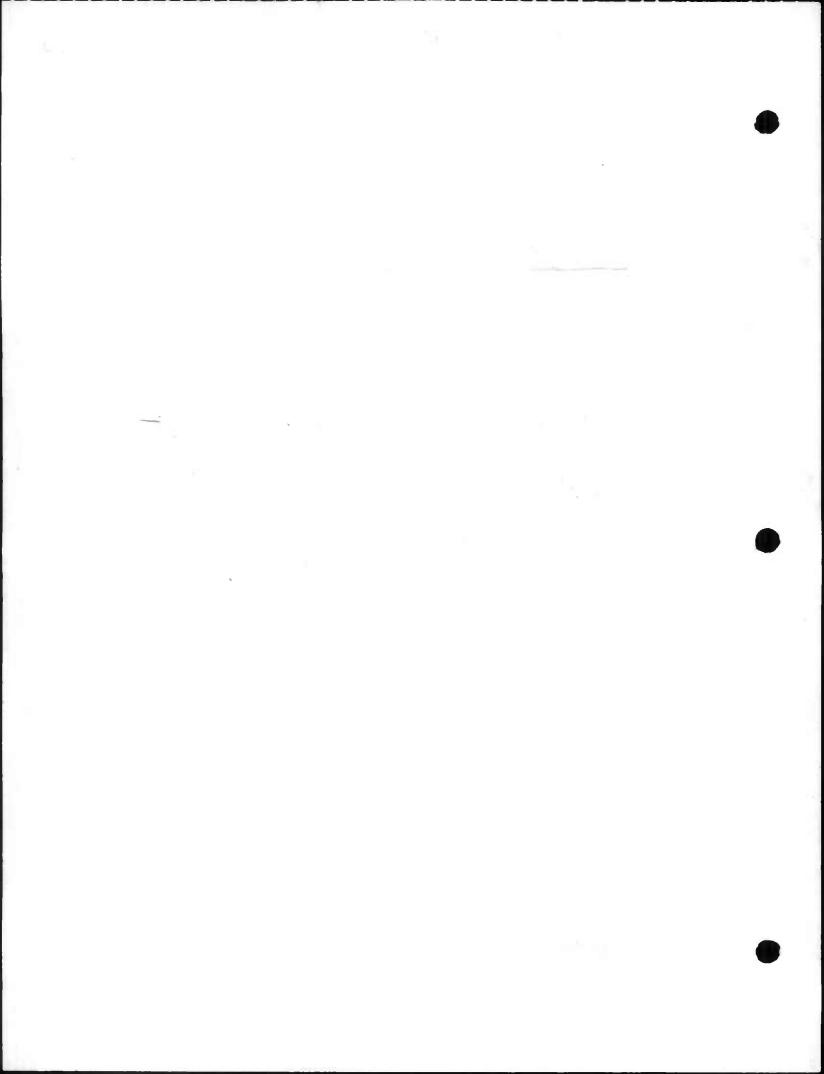
DIVISION OF VITAL RECORDS, P.O. BOX 68760,

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		U	ENITE	CAIL	OF	DEATH		REG. NO.			
	1. DECEOENT'S NAME (First, Middle, Last)							2. DATE OF	DEATH DA		YEAR	3. TIME OF DEATH
	Fannie Robi	inson						1.2	10	*	94	M
- 8	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. la	ast birthday)	IF UNDER 1		IF UNDER 24 HRS.	7. DATE OF	BIRTH		B. BIRTH	IPLACE (State or Foreign
	216-10-3869	1 🗌 M 2🔀 F	81	YRS.	MONTHS	DAYS	HOURS MIN.	May	2 7	13	Countr	γ)
	9e. FACILITY NAME (If not institution, give s	treet and number)	OI		9b. CITY	TOWN	OR LOCATION OF DI		4 /		NTY OF D	VA
œ			_ 1							SC. COO.	NIT OF D	CAIN
6	Union Memorial	nospit	d1		Ba	ilt	imore C	ıty				
<u> </u>	10+. STATE 10b. COUNTY	Y		10c. CITY	, TOWN OF	R LOCAT	TION					10d. INSIDE CITY
E	MD				D	201	timore	Ci+++			- 1	LIMITS?
1		smouth		4	1.		T T III O T G	отгу		10a CIT	ZEN OF	VHAT COUNTRY?
FUNERAL DIRECTOR							. =		iog. GH		mai Contratt	
2	7112 Postsmout	12. WAS DECEDEN		21207						USA		
5	1 Never Merried 2 Merried	FORCES? 1	YES 2 X	S. ARMED 13. WAS DECENDENT OF HISPANIC If yes, specify Cuben, Mexicon, I					Specify Yes in, atc.)	or No-	14. RACE Black	— Americen Indien, c, White, etc.
В	3√XWidowed 4 □ Divorced	IF YES, GIVE W	AR OR DATES		1	YES	2 NO Specif	y:	-C565		Speci	
	15 DECEMENT'S ENLI	CATION	1									Black
쁘	15. DECEDENT'S EDUC (Specify only highest grade	completed)	(0	ECEDENT'S	rork done du	uring mo	ON st of working	16b. KI	ND OF BUS	INESS/INC	DUSTRY	
	Elementary/Secondary (0-12)	College (1-4 or 5+) Im	b. Do NOT us								
M	1			Nev	er E	mp.	loved					
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S NA	ME (First, Midd	lle, Meiden S	Surname)		1.0
BE	George Harper						Marth	a Kir	12			
	19a. INFORMANT'S NAME (Type/Print)						nd Number or Rural	Route Number,	City or Town			
2	Bernice N. Bro	onson					nouth R					201
	20e. METHOD OF DISPOSITION		20b. PLACE	AND DATE O	F DISPOSIT	TION /Na	me of	DATE	20c. LOC	ATION —	City or To	wn. State
	NBurtel 2 ☐ Cremetion 3 ☐ Remo	ovat from State	cemetery, cri	rematory or oth	har placa)	ωm	12/1	11/9/1	Ra I	timo	ro i	VID.
	21. SIMATURE OF FUNERAL SERVICE LIC	CENSEE	MEDLE	ידוו טו			I Z / I		Dal	CHIIO	١ ,	.ш/
- 1	6 6 0 0 0	11 11	\circ	Unity Funeral					Home			
		Valla			1	0.8	W. Nor	th Av	Α.	Bal	to	MD 21201
	23. PART I. Enter the diseasea, or o	complications that	caused the d	eath. Do n	ot enter t	he mo	de of dying, suc	h ss cardiac	or respir	atory arr	rest,	Approximate
	shock, or heart fellure.	List only one ceu	se on each line	e.								Intervel Bstween
	IMMEDIATE CAUSE (Fine) disease or condition A A A A A A A A A A A A A											
	disease or condition s. A Zheimer's Disease oue TO (OR AS A CONSEQUENCE OF): Multintartian Denertian											
		DOE TO	OH AS A CONSE	OUENCE OF); / \		1	1 .				
No	Sequentisity list conditions,					N	pene	1774				
CERTIFICATION	If sny, leading to immediate	DUE TO	(OR AS A CONSE	OUENCE OF	J;							
<u></u>	CAUSE (Disease or Injury	с										
# 1	that initiated events resulting in death) LAST	DUE TO	(OR AS A CONSE	OUENCE OF):							
H	resulting in destin) LAST	d										
	PART II. Other aignificent condition	s contribution to	death but not	regulates 1	n the	lagis d	n name about	Post I		u cross	1	
EDICAL	in other aignificant condition	- continuum to	death but not	resulting li	ii the und	eriying	g ceuee given in	Pert I. 24	a. WAS AN A		_ 24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
ă								_ 1	YES 2	NO		COMPLETION OF CAUSE OF DEATH?
												1 YES 2 NO
=	DID TOBACCO USE CONTI	RIBUTE TO CA	USE OF DEA	ATH YE	S 🗆 N	ОГ	UNCERTAIN	N 🗆 l				
<u> </u>	25. WAS CASE REFERRED TO MEDICAL			CE OF DEAT								
S	EXAMINER?	HOSPITAL:	ER/Outpatient		OTHER:		e € □ Bestdone:	A [] Otton 10				
PHYSICIAN: M	27. MANNED-OF DEATH	28e. DATE OF		26b. TIME		ng Hom	e 5 🗆 Residence			IIIpv oo	CHREC	
	1 Natural 5 Pending	(Month, De		INJU		WO	RK?	26d. DEŞCRI	DE HOW IN	JUNY UC	COMED	
à I	2 Accident Investigation						ES 2 NO					
	3 Suicide 6 Could not be	28e. PLACE Of building,	ome, term, at	treet, factor	ry, office		281. LOCATIO	ON (Street er own, State)	nd Number	or Rural R	loute Number,	
	4 Homicide determined											
Solution of the determined building, etc. (Specify) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date and place, en								to the causer	e) end men	ner en stet	ed.	
One) 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner se stated.) end menner ee stated			
8												
B	29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Ybar)											
စ္	non 2. I	were					116.	334		-/	2//	4/90
-	30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUS	E OF DEATH (ITE	М 27) (Туре,	Print)	,	0	01	0	, ,		7
	Marc D. Lo	Kolow.	17(1)	30	15	to 1	Vaul 1	luc	Bo	110.	on	11/202
	31. DATE FILED (Month, Day, Year)	13 NEGISTA	R'S SIGNATURE	fall	- /		,			, -		
	DEC 16 1994	your our	Therefore, IVAN	C-GE								
	The second secon	44										



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an intermediate for many be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLAN		NT OF HEALTH AND TE OF DEATH	MENTAL HYGIENE REG. NO.					
	DECEDENT'S NAME (First, Middle, Last) A. SOCIAL SECURITY NUMBER	John K	s. last birthday) IF Un	DER 1 YEAR IF UNDER 24 HRS.	2. DATE OF DEATH DAY	YEAR 94 0747 A M				
	98. FACILITY NAME (If not institution, give str	1)XM20F 3L	YRS. MONTH	S DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 4-4-60	6. BIRTHPLACE (State or Foreign Chuntry)				
DIRECTOR	Mesidence of Decedent	Hospital		Da. A. 11-1	wn	COUNTY OF BEATH				
	10a. STATE 10b. COUNTY		Ba	N OR LOCATION		10d. INSIDE CITY LIMITS? 1 - YES 2 NO				
FUNERAL		4 Essex Rd 21207								
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	NIC ORIGIN? (Specify Yea or Nean, Puerlo Rican, etc.) Ifly:	14. RACE — American Indian, Black, White, atc. Specify: BLUK							
COMPLETED	15. DECEDENT'S EDUC, (Specify only highest grade of Elementary/Secondary (0-12)	ATION 164 completed) College (1-4 or 5+)	Give kind of work do life. Do NOT use retire	ne during most of working d.)	16b. KIND OF BUSINES	SS/INDUSTRY				
	17. FATHER'S NAME (First, Middle, Last)	agre)								
TO BE	19a. INFORMANT'S NAME (Type/Print)	SS	19b. MAILING ADDR	ESS (Street and Number or Rura ESS & R	Route Number, City or Town, Sti	ate, Zip Code)				
	20a METHOD OF DISPOSITION 1 Description 2 Cremation 3 Remove 4 Donation 3 Other (Specify)	val from Stata cemetry	ACE AND DATE OF DISI y, cremetory or other pla UE131 AE		DATE 200 LOCATION	ON — City or Town, State				
	21. SIGNATURE OF FUNERAL SERVICE LIO	March		22 NAME AND ADDRESS OF F AUGUST H 4300	West weekersh	Ave Balto, Ad 21215				
-	23. PART I. Enter the diseases, or conshock, or heert fellure. L. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	pmplicetione that ceueed the list only one cause on each course to course on each course to cour	e deeth. Do not en line.	Cardian rsluthe	ch ss cardiec or respirato	ry errest, Approximate interval Between Onset and Death				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST									
A	PART II. Other algnificent conditions	OPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?								
PHYSICIAN: MEDIC	DID TOBACCO USE CONTR		PLACE OF DEATH (Che		N 🗆	1 VES 2 NO				
35 		HOSPITAL: 1 Inpetient 2 ER/Outpetier	nt 3 N DOA 4 1	IER: Nursing Home 5 - Rasidenca	6 Other (Specify)					
ВУ РН	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJUR	Y OCCURED				
	3 Suicide 8 Could not be determined	28a. PLACE OF INJURY — A building, etc. (Specify)	28s. PLACE OF INJURY — At home, ferm, street, fectory, office			umber or Rural Route Number,				
COMPLETED		(Check only 1 CERTIFFING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) end menner as stated.								
IO BE C	296. SIGNATURE AND TITLE OF CERTIFIER	MM.D.		D 20	18/	1. DATE SIGNED (MONTH, Day, Year)				
	JAMES K			Ambassa	ador Rd.	Balt. Md				
	31. DATE FILED (MONTH, Day, Year) DEC1 6 1994	32. BEGISTRAP'S SIGNATUR	Kerdall		- 171					

, ITEMS: 23 PART I, II, 27, 28a-f, PER MEO FILM G-718 12/17/94 t.t

		FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAI CERTIF	RTMENT OF	HEALTH AND F DEATH	MENTA	L HYGIEN REG. NO.	E		
		1. DECEDENT'S NAME (First, Middle, Last) FRANKIE	A7K7A John PAUL	Wisber	y RAT	MONDI D	2. DATE MONT			EAR	TIME OF DEATH 3:46 A
P		4. SOCIAL SECURITY NUMBER 219 42 1459		(In yrs. lest birthday)		R IF UNDER 24 HRS.	7. DATE (Mont	of BIRTH th. Day, Year)	8.	BIRTHPL.	ACE (State or Foreign
2, 3 should	TOR	98. FACILITY NAME (If not institution, give: FRANKLIN SQUAF	,	1		N OR LOCATION OF D			9c. COUNTY OF DEATH Baltimore		
Pages 1,	DIRECTOR	10s. STATE 10b. COUNT		10c. Ci	TY, TOWN OR LO	cation					d. INSIDE CITY LIMITS?
sit permit.		Md. City 100. STREET AND NUMBER				101. ZIP CODE 21220			-		XYES 2 NO
5-0020 nding physician. ss the burial-transit	BY FUNERA	4 Aber Drive 1 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 XYES IF YES, GIVE WAR OR D	2 NO	If yes,	DECENDENT OF HISPA specify Cuban, Maxic (ES 2 NO Speci	en, Puerto		or No.— 14.	RACE -	American indian, thite, etc.
2121 al or atte	LETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	ICATION	16a. DECEDENT'S (Give kind of life. Do NOT of	work done during use retired.)		168	. KIND OF BUS	INESS/INDUS	TRY	
YLAND 21 by the hospital or be detached for u at once.	COMPL	H . S . 17. FATHER'S NAME (First, Middle, Last)		Unkno	wn	16. MOTHER'S NA			NK NOW	n.	
MAR retained to 5 should	TO BE	19a. INFORMANT'S NAME (Type/Print) Joseph P. Comi	aimondi ma	196. MAILIN	E. Mai	et and Number or Rural	Route Num	ber, City or Town	n, State, Zip Co	de) D. 2	21157
MORE, age 6 may be director, page		20a METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Rem 4 Donation 5 Other (Specify)		PLACE AND DATE		Veteran St Cemet	sDec	20c. LOG	1994	or Town,	State M.d.
ALII death. P funeral examin		21. SIGNATURE OF FUNERAL SERVICE LI	Haight			Box 195]	Haight	Fun	eral	1 Home
60, d within 24 hours after ompletely filled in by the cremation, or removal event, the medical		23. PART I. Enter the diseasea, or shock, or heert failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	a. ACUTE NARCO	ach lina.	CAINE IN		ch as can	diec or raapi	ratory arrest	,	Approximate interval Between Onaet end Des
be execute cian and co for to buria	CATION	Sequentielly list conditione, if any, leeding to immediate cause. Enter UNDERLYING	b DUE TO (OR AS A	CONSEQUENCE (DF):						
death certificate attending physiental Hygiene print, or other to	CERTIFIC	CAUSE (Disease or injury that initieted eventa resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF):								
at the by the wind M	MEDICAL C	PART II. Other algoriticent condition CIRRHOSIS OF LIVER	ne contributing to deeth b	out not resulting	in the underly	ing ceuee given in	Part I.	24s. WAS AN PERFOR	MED?	AM CC OF	ERE AUTOPSY FINDING AILABLE PRIOR TO OMPLETION OF CAUSE DEATH? YES 2 NO
AL ME The law requi the has been s the Dept. of H m 23 shov		DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH Y			Ν□				
SICIAN: The certificate he the State he the State he the state he the	PHYSICIAN:	EXAMINER? 1 Yes 2 NO 27. MANNER OF DEATH	HOSPITAL: 1 Inpution 25 ER/Outs 28a. DATE OF INJURY	285 TH	45 OF 280 I	ome 5 Residence	T	or (Specify) SCRIBE HOW IP	HIEV OCCUR	ED.	
ON ON OTHER PHYSIC DEATH WITH STREET WITH STREET WITH STREET WITH STREET PHYSIC DEATH WITH STREET, STREET PHYSIC DEATH PHY	ВУ Р	1 Natural 5 Panding 2 Accident Investigation	(Month, Day, Year) FOUND 12-3-9	FOUNT 3:00	A M 1	WORK? YES 2 (()(NO	UNKI				
DIVISION OF VITAL RECO- DR ATTENDING PHYSICIAN: The law requires th DIRECTOR: After this certificate has been signed hours after death with the State Dept. of Health item 28 is marked, or item 23 shows an	9	3 Suicide axXXX Could not be datermined	28s. PLACE OF INJURY building, atc. (Spec	FOUND /	AT HOME		BALT	IMORE CO	4 E. AL.	Pural Poul DER D	
- 2 - 4	COMPLET		ICIAN: To the best of my know ER: On the basis of examination							nuse(a) ar	nd manner as stated.
TO THE HOSPIT TO THE FUNERA De filed within 7	TO BE	SON MONATURE AND TITLE OF CENTSPIE	Alle	7 (1)		29c. LICENSE NU		. DE	29d. DATE SI		onth, Day. Year)
		MARD + GOLL	O COMPLETED CAUSE OF TOE	111 Per		eet, Bal	Ltim	ore,	Maryl	and	21201
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Nameurs after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the afterding physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should	be filed within 72 hours after death with the State Lept. of Health and Mental Hygiene prior to burial, cremation, or removal.	MEDOCAMP 16 Hours 29 is morked as them 22 shours one interest on other tenuments accomplished accomplished an entitied at

DEC16 1994

HERITAL ASSIST

	FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND /	DEPAF	RTMENT OF	HEALTH	AND I	MENTAL HYGIEN			
•	1. DECEDENT'S NAME (First, Middle, La	(St)	?.		2upp	1	i H	2. DATE OF DEATH MONTH DA	NY .	YEAR 4	3. TIME OF OEATH 17:02 p M
	4. SOCIAL SECURITY NUMBER 220-09-3594	5. SEX	6. AGE (In yrs. les	t birthday) YRS.	IF UNDER 1 YEAR		R 24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Ybar)	909 Mary		IPLACE (State or Foreign
TOR	9a. FACILITY NAME (If not institution, gi 205 Pleasant RESIDENCE OF DECEDENT	Hill Rd.			96. CITY, TOW Owi	n or locati		EATH	eath nore		
DIRECTOR	10a. STATE 10b. COU			t0c. CIT	Owings		5		10d. INSIDE CITY LIMITS? 1 YES 2 W NO		
FUNERAL	100. STREET AND NUMBER 205 Pleasan	t Hill Rd.				10f. ZIP COO	£117		tog. CIT		S.A.
ВУ	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDEN FORCES? 1 IF YES, GIVE W	T EVER IN U.S. AR							- American Indian, k, Whita, atc.	
COMPLETED	(Specify only highest grade completed)				ECEDENT'S USUAL OCCUPATION live kind of work done during most of working . Do NOT use retired.)						Walde
BE COMP	17. FATHER'S NAME (First, Middle, Lest) Ernest Ward		Sup	erviso	18. MOT		ME (First, Middle, Meiden : Baker	phor Surneme)	10		
TO B	19a. INFORMANT'S NAME (Type/Print) Charles G. Gamber 19b. MAILING AGORESS (Street and Number or Rural Route Number, City or Town, Stella, Zip Code) 1925 Pine Knob Rd., Sykesville, Md. 21784										
	20a. METHOD OF DISPOSITION 14 Burlal 2 Cremation 3 R 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE		20b. PLACE A	matory or o		ry Dec		1994 Woo	ation –	City or To	wn, Stata Id•
	· H.J. 2.	Chardt or complications that re. List only one cau	of:	Do not enter the mode of dying, such as cerdiac or respiratory arrest, Caran Variable Caran						Approximata Interval Batween	
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):										
PHYSICIAN: MEDICAL C	PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Ce-ch									AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
YSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 JAN	HOSPITAL:	ER/Outpatient 3	□ DOA	OTHER:	PLACE OF D	_	ack only one) 8 Other (Specify)			
B	Natural 5 Pending Accident Investigation Suicide 8 Could not investigations.	28a. PLACE O	ny, Year) F INJURY — At hor		M t	NJURY AT WORK? YE\$ 2	NO	28d. DESCRIBE HOW IN 281. LOCATION (Street as			oute Number
COMPLETED	4 Homicide determined 29a. CERTIFIER (Check only 1 CERTIFYING PH	YSICIAN: To the best of	my knowledge, dea	eth occurre	ed at the time, d	nta and placa		to the ceuse(a) and man	ner aa stat	ted.	
BE CO	29b. SIGNATURE AND TITLE OF CERTIF				n, in my opinior	29c. LICE	ENSE NUM	time, data and place, and			(Month, Day, Year)

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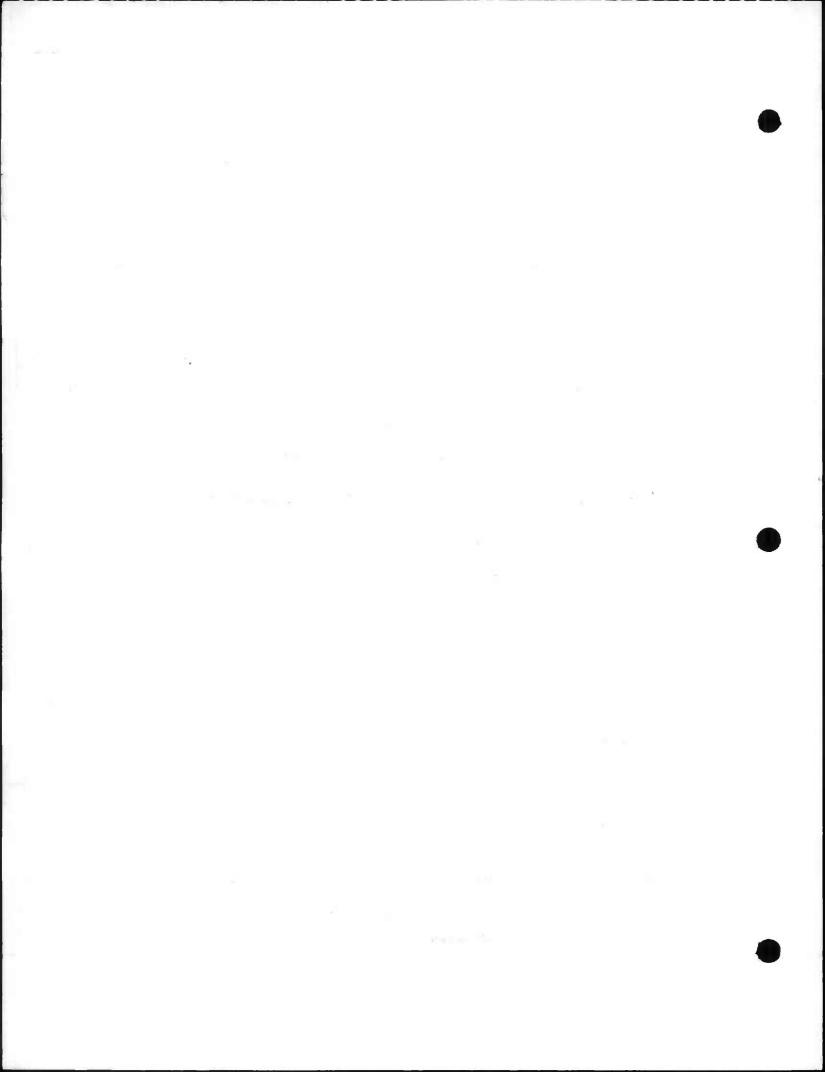
31. °DECT 6 1994

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Carol Richardson M.D. 9000 Franklin Square Dr.

	u.	EM. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit pen		
	MIL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	e bunal-t		
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	e law rec	has beer	Dept. of	23 sh
	IAN: Th	tificate	e State	or item
	PHYSIC	r this ce	h with th	arked,
	TENDING	DR: After	mental hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	fill item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
	DR ATT	DIRECT	hours at	item 2
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						91	4 3/330		
	FOR STATE OF B	IARYLAND / DEPAR	TMENT OF I	JEALTH AND AN	ENTAL HYOLEN				
,	1 - STATE REGISTRAR		ICATE OF		ENIAL HYGIEN REG. NO				
	1. DECEOENT'S NAME (First, Middle, Last)				2. DATE OF DEATH	AY.	3. TIME OF DEATH		
	Audrey Beatrice Ray	nond	1		ecember		⁶ 94 10:15 P.™		
		6. AGE (in yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	- 1	BIRTHPLACE (State or Foreign Country)		
	218-18-4089 1 M 2 K F 9a. FACILITY NAME (If not institution, give street and number)	69 THS.	9b. CITY, TOWN	OR LOCATION OF DEAT	ebruary 8		Maryland Y OF DEATH		
e e	Meridian Health Care Cent	02		ville			lto.		
DIRECTOR	10s. STATE 16b. COUNTY		Y, TOWN OR LOCA						
E E	Maryland			1.765			10d. INSIDE CITY LIMITS? 1 V YES 2 NO		
	10e. STREET AND NUMBER		altimore 10	f. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?		
FUNERAL	2531 Glencoe Road			21234		I - п	SA		
15	1 Never Married 2 Warried FORCES? 1	EVER IN U.S. ARMED YES 2 NO	13. WAS DEC	CENDENT OF HISPANIC hecify Cuban, Mexican, I	ORIGIN? (Specify Yea	or No — 14	I. RACE — American Indian, Black, White, atc.		
B	3 Wildowed 4 Divorced	AR OR DATES X		2 NO Specify			Specify: White		
03	15. DECEDENT'S EDUCATION (Specify only highest grade completed)		USUAL OCCUPATION		16b. KIND OF BUS	SINESS/INDUS			
9	Elementary/Secondary (0-12) College (1-4 or 5 -	Him Do MOT us	se retired.)	ost of working					
COMPLETED	12 17. FATHER'S NAME (First, Middle, Last)	Homen	naker	T		Home			
					E (First, Middle, Maiden Arinas	Surname)			
BE	Rraden Russell 19a. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street a	n, State, Zip Co	ode)				
2	John F. Raymond		ne as 10						
	20a, METHOD OF DISPOSITION 1 [X Burlal 2] Cremation 3] Ramoval from State	20b. PLACE AND DATE of cemetery, crematory or of	OF DISPOSITION (Na		DATE 20c. LO	CATION — CIT	y or Town, State		
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Gardens o	of Faith	12/19/94 ND ADDRESS OF FACIL	1 B	alto.	Md.		
	21. SIGNAL DIE DI PUNERAL SERVICE LICENSEE			and J. Ruc					
_	Monald C. Scholer S.		5305	Harford F	21214				
	23. PART I. Enter the diseases, or complications the shock, or heart failure. List only one cau	caused the death. Do r sa on each lina.	not entar tha mo	da of dying, auch a	na cardiac or reapi	ratory arres	t, Approximate Interval Between		
	IMMEDIATE CAUSE (Final disease or condition	10					Onset and Death		
	resulting in death) a. STVO	OR AS A CONSEQUENCE OF	F):						
Z	Sequentially list conditions, b. Ather	oclevotec	Cereb	rovascu	lau Dis	seuse	phemonta		
ERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	OR AS A CONSEQUENCE O	F):						
5	CAUSE (Disease or Injury C.	OR AS A CONSEQUENCE OF	n:						
E	resulting in death) LAST						į ,		
O	PART II. Other significant conditions contributing to	death but as a soulder	In the condition						
MEDICAL	Diabetes mellitu		in the underlying	g cause given in Pa	PERFOR		24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE		
0	The The The That				_ 1 _ YES 2	THO	OF OEATH?		
≥ :	DID TOBACCO USE CONTRIBUTE TO CA	JSE OF DEATH YE	S I NO I	UNCERTAIN	M		1 - YES 2 1 10 NO		
NA N	25. WAS CASE REFERRED TO MEDICAL	28. PLACE OF DEAT	TH (Check only one)	3 OTTOERTAINT					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? 1 YES 2 NO OTHER 1 Inpallent 2 ER/Outpatient 3 DOA OTHER 27. MANNER OF DEATH 28a. OATE OF INJURY 28c. INJURY AT WORK? WORK? WORK?									
	27. MANNER OF DEATH 28a. OATE OF (Month, De (Month, De)		JURY WO	PRK?	ad. OEŞCRIBE HOW II	NJURY OCCUP	REO		
В	2 Accident Investigation	INJURY — At home, term, (YES 2 NO	8f. LOCATION (Street a	and Mumbur or	Prival Pourts Mumber		
1ED	4 Homicide 8 Could not be building,	etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	. [.	City or Town, State)	ind regimber of	Parel House Nomber,		
PLE	29a. CERTIFIER (Check only	my knowledge, death occurr	ed at the time, data	and place, and due to	the cause(a) and men	ner as stated.			
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of as								
ш	29b. SIGNATURE AND TITLE OF CERTIFIER			29c. LICENSE NUMBE	ER				
8	Karol Lehardson mi)		D4630	3				



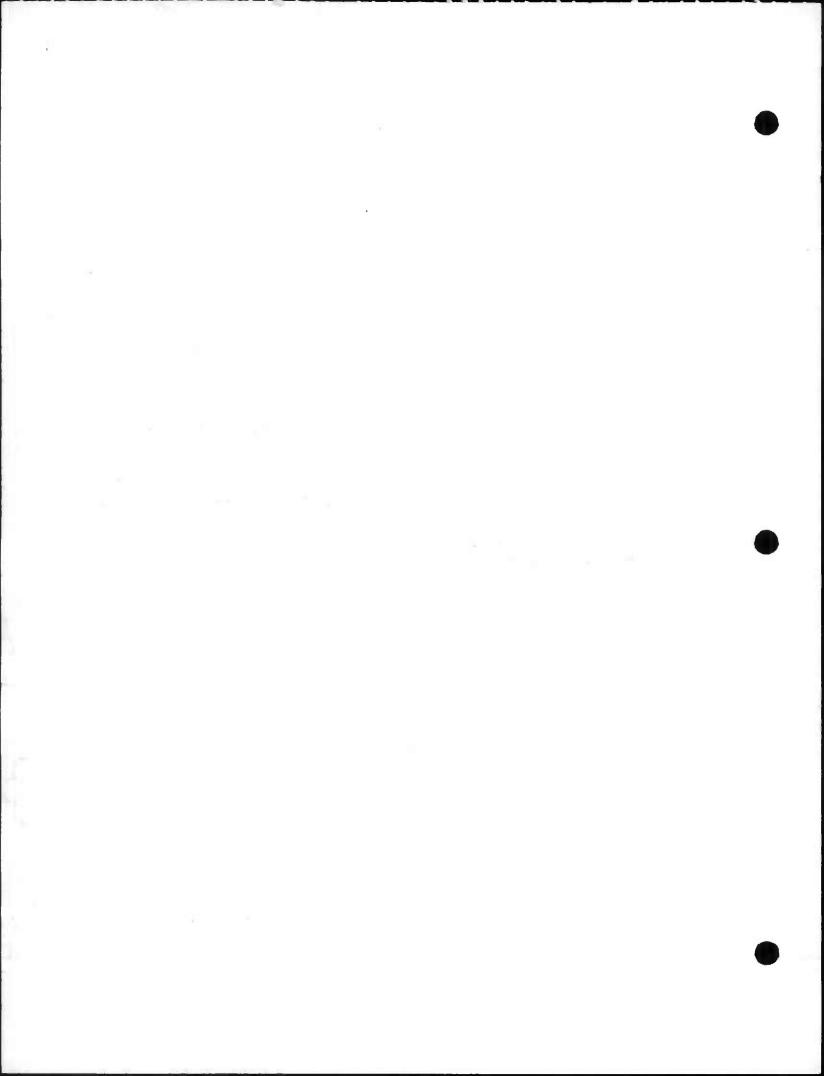
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TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 44 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYLA		MENT OF H		MENTAL	HYGIEN	E			
	1. DECEDENT'S NAME (First, Middle, Last)					BACAPTA	OF DEATH		- 40	TIME OF DEATH	
	William \mathcal{J} .		RASSA	-		Dece	mber	2, 199	94 12	2:28 pm. m	
-	/	SEX 6. AGE (In	yrs. lest birthday) 87 YRS.	MONTHS DAYS	HOURS MIN.	Jun.	DE BIRTH Day, Year)			NCE (State or Foreign	
_	9a. FACILITY NAME (If not institution, give street			9b. CITY, TOWN O	2_/	9c. COUNTY	OF DEAT	yland			
DIRECTOR	Franklin Squar	<u>e Hosoital</u>	<u> </u>	Balt	imore			Balti	nore		
REC	10a, STATE 10b, COUNTY		10c. CITY,	10c. CITY, TOWN OR LOCATION				10d. INS			
	Md. Balt	imore	B a	Ltimon	C ZIP CODE					YES 2 NO	
FUNERAL	56 Dogwood Dr.				2/220			10g. CITIZEN	S.A		
S	11. MARITAL STATUS 12	2. WAS DECEOENT EVER IN I	U.S. ARMED		ENDENT OF HISPAI					American Indian.	
BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT			2 ⋈ NO Specif		rcon, etc.)		Specific	White	
9	15. OECEDENT'S EDUCATI (Specify only highest grade con	ION mpleted)	18e. DECEDENT'S U	ISUAL OCCUPATION OF A done during mo	ON st of working	16b,	KINO OF BUS	INESS/INDUST		where	
9		College (1-4 or 5 +)	ille. Do NOT use	retired.)	st or working		2 1 :	more	C · 1		
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		leach	er_	18. MOTHER'S NA	_			CLT	<u>y</u>	
BE C	August Rassa				Anna			,			
5	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADORESS (Street e	nd Number or Rural	Route Numb	er, City or Town	n, State, Zip Coo	de)		
	Mrs. Anna G. Ra.		56 D	agwaad	Dr. Bo	1/to	Md.	2/22 CATION — City	0		
	1)CDBurlel 2 Cremetion 3 Removal 4 Donetion 5 Other (Specify)	I from State cemet	tery, cremetory or oth	er place)	me or	1		alto.			
	21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE		22. NAME AP	D ADORESS OF FA	CILITY				•	
	23. PART /. Enter the diseases, or com	Snaith		7527	Hunlon	ler d Ro	rune I Ra	ral #	ome	21234	
	23. PART /. Entar the diseases, or com- shock, or heart/fallure. List	iplications that caused to only one ceuse on eec	the deeth. Do no	ot enter the mo	de of dying, suc	h as card	lec or respi	ratory errest	,	Approximata interval Between	
1	immediate cause (Fine) disease or condition Myoccive Light To face trion										
ŀ	disease or condition resulting in death) a. MYO CARCUAL Intacction DUE TO (OR AS A CONSEQUENCE OF):									Multos.	
Z	Sequentially the condition of b. NIDDM.										
ATIC	Sequentially list conditions, If any, leading to Immediate cause. Enter UNDERLYING										
FIC	CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSEQUENCE OF):										
CERTIFICATION	resulting in death) LAST										
AL C	PART II. Other eignificent conditions c	ontributing to deeth but	t not resulting in	the underlying	cause given in	Part I.	24a. WAS AN			RE AUTOPSY FINDINGS	
	Essential T	remor, B	PH.				PERFOR		CO	JLABLE PRIOR TO MPLETION OF CAUSE DEATH?	
ME		/						1		YES 2 NO	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		DEATH YES		UNCERTAIL	N 🗆]					
SIC		OSPITAL:	A. 0	OTHER:	e 5 🗆 Residence	8 Other	(Specify)	utsic	1014	one.	
F	27. MANNER OF OEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	OF 28c. INJ	URY AT			JURY OCCUR		07.00	
₽	2 Accident Investigation	28e. PLACE OF INJURY -	At home feet at		rES 2 NO		71011 101				
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	building, etc. (Specify	/)	eet, ractory, onic		City o	r Town, State)	nd Number or F	tural Floute	Number,	
2	29a. CERTIFIER (Check only 1) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) and manner se stated.										
S S		On the basis of examination e							use(s) en	d manner as stated.	
8	29b. SHOMATURE AND TITLE OF CENTURER	1/0100	m		29c. LICENSE NUN	MBER 2///		29d. DATE SIG	GNEO (Mo	nth, Day, Year)	
요.	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETEO CAUSE OF OEAT	'H (ITEM 27) (Type F	Print)	W379	7/		10	-/3	3-74.	
A	SUSAN G. WE	iner MD	56	01 200	1 Rave	n B	100	Balt.	- M	12/239	
	DECTO 1994 Juli	32. REGISTRAR'S SIGNAT								0.70.07.	
- 11	APA 1934 AND	distribution hards	ll.								



IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE

·Add. Info. FilmG718 12/17/94 kam

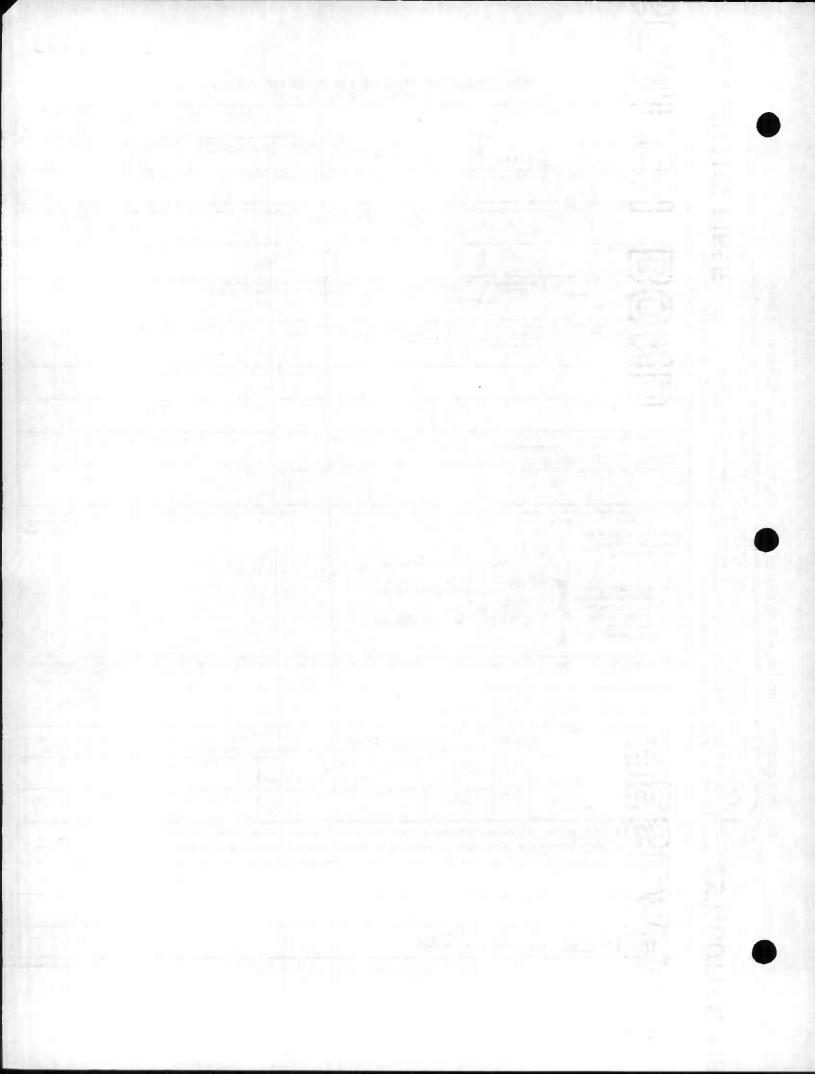
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIFICA	TE OF DEATH	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Lest) Cooper LaVell	REID		2. DATE OF DEATH DAY	,1994	3. TIME OF DEATH 6.03 PMM		
	1 M 2 🗆 F	B. AGE (In yrs. lest birthday) VRS. MONTH	DER 1 YEAR IF UNDER 24 HRS. IS DAYS HOURS MIN. 3 (7. DATE OF BIRTH (Month, Day, Year)	Country	PLACE (State or Foreign		
TOR	90. SACILITY NAME (If not institution, give street and number) IN NCC GUOGO TOSPITE RESIDENCE OF DECEDENT) 96. C	Levery M		9c. COUNTY OF DEATH			
DIRECTOR	Md. Prince Geo		N OR LOCATION Ditol Heights			10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
FUNERAL	1417 Nova Avenue, #303		101. ZIP CODE 20743		10g. CITIZEN OF W			
BY FUN	11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT FORCES? 1 IF YES, GIVE WAI	TES 214)NO	IS. WAS DECENDENT OF HISPAI If yes, specify Cuben, Mexico 1 YES 2 XNO Specif	m, Puerto Rican, atc.)	or No — 14. RACE Black, Specify	- American Indian, White, etc.		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5 +)	life. Do NDT use retire	ne during most of working	16b. KIND OF BUSI	NESS/INDUSTRY	DIACK		
OM	17. FATHER'S NAME (First, Middle, Last)	none	16 MOTHER 10 NA	ME (First, Middle, Meiden S				
Ö	William Anthony Cooper				urname)			
BE (19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDR	ESS (Street end Number or Rural	Vetta Reid	State 7in Code)			
5	Mother	1417	Nova Avenue,	#303 Capi	tol Heigh	0743		
	20s. METHOD OF DISPOSITION 1 □ Burlel 2 □ Cremation 3 □ Removal from State 4 □ Donetion 5 I% Other (Specify) → + + + + + + + + + + + + + + + + + +	20b. PLACE AND DATE OF DISP cemetery, crematory or other place	OSITION (Name of		ATION — City or Tow			
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		2. NAME AND ADDRESS OF FA	CILITY				
CERTIFICATION	Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death Interval Between Onset and Death Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):							
PHYSICIAN: MEDICAL CE	d							
NA.	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE DF DEATH (Ch	eck only one)				
VSIC	, HOSFIAL.	R/Outpatient 3 DOA 4 N	ER: ursing Home 5 - Residence	6 Other (Specify)				
ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending (Month, Day. 2 Accident Investigation	JURY 28b. TIME OF	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJ	URY OCCURED			
		NJURY — Al home, ferm, atreat, fi c. (Specify)	actory, office	281. LOCATION (Street end City or Town, State)	I Number or Rural Ro	ute Number,		
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the beel of my one) 2 MEDICAL EXAMINER: On the basis of examples	r knowledge, death occurred at the	e lime, date and piece, end due y opinion, death occured at the	To the cause(s) end manner time, data and place, and	or ea stated.	end manner es stated.		
BE C	296. SIGNATURE AND TITLE OF CERTIFIER WITH A LOUPE T	MD.	29c. LICENSE NUM	IBER	Ped. DATE SIGNED (1)	Month, Day, Year)		
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE	hre George	107 Hospital	Cherely	MO.			
	DEC1 7 1994 July Star	signature to the second	,					

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DIVISION

	1. DECEDENT'S NAME (First, Middle, Las	^						2. DATE OF D	EATH DAY		EAR 3.	TIME OF DEATH		
	WILLYA		NSDI					12	10	^	1	1025		
	4. SOCIAL SECURITY NUMBER		6. AGE (In yrs. lesi	- "	IF UNDER 1	EAR IF U	NDER 24 HRS.	7. DATE OF BI (Month, Day,		8.	BIRTHPLA Country)	NCE (State or Foreig		
	217-03-002	1 M 2 D F	95	YRS.				Jan 21				ginia		
BY FUNERAL DIRECTOR	9a. FACILITY NAME (If not institution, give itreet and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY Northwest Medical Center Baltimore								OF DEAT	Н				
	Northwest Medica	Northwest Medical Center					re							
	10a. STATE 10b. COU			10c. CIT	, TOWN OR	LOCATION					10	d. INSIDE CITY LIMITS?		
	Maryland	Baltimore							17	YES 2 N				
	10e. STREET AND NUMBER					10f, ZIP (CODE			10g. CITIZE	N OF WHA	T COUNTRY?		
	1822 Presstman S					-	1217				JSA			
	11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	YES 2 XN	MED IO	- If y	es, specify (NIC ORIGIN? (Sp an, Puerto Rican, ly:		No- 14		American Indian		
ED	16. DECEDENT'S E (Specify only highest gr	DUCATION	16a. DE	CEDENT'S	USUAL OCC	JPATION	un elide és	16b. KIND	OF BUSIN	ESS/INDUS	TRY	DLack		
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	Min	Do NOT us	vork done dur e retired.)	ing most of W	rorning							
MP	11th Grade			Wai	ter					prin	q Ir	nn		
	17. FATHER'S NAME (First, Middle, Last)							ME (First, Middle		mame)				
BE	Sidney Ransom 19a. INFORMANT'S NAME (Typo/Print)				4000000			ude La						
2		ncom Tr						Route Number, Ci				22		
	William M. Ransom, Jr. 9809 Winands Road Randallstown, MD 211													
	1 X Burial 2 Cremation 3 R	emoval from State	cemetery, cred	matory or of	her place)		er,	Dec ₄						
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE	I Weste.	III St	22. NA	ME AND AD	DRESS OF FA	Nut	bd I	TUNOR	e, M	aryland		
	Doville of	Roller	2		20	JI GW	yillis r	alls r	TIKWO	У	al. no	AUGS, I		
	23. PART I. Enter the diseases, of			eth Do s				aryland	212		1	Approxima		
CERTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (C	OTHY OR AS A CONSECUTION OF	DUENCE OF	DIS	m								
	PART II Other significant condit	ions contributing to d	feeth but not e	equiting I	n the und	rlulna cau	re alven la	Bert I Dan	MAR AN AI	maney	T 0.45 Mar	DE ALERODAY EN		
DICAL	PERCY TRAVEOUS ENDOSCOPIC GASTROSTOMY 1 YES 2 NO OF								RE AUTOPSY FII AILABLE PRIOR 1 MPLETION OF C DEATH?					
MED	25. WAS CASE REFERRED TO MEDICAL					26. PLACE (OF DEATH (C)	neck only one)						
	EXAMINER? HOSPITAL: OTHER:													
	EXAMINER?	1 YES 2 NO 1 No Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									RED			
	and the second s	28e. DATE OF II	NJURY			1 Natural 5 Pending (Month, Day, Year) INJURY WORK?								
PHYSICIAN:	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF II (Month, Day	NJURY			WORK?	2 🗌 NO	Zed. DESCRIB						
TED BY PHYSICIAN:	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF H (Month, Day) on 28a. PLACE OF building, e	NJURY	INJ	URY M	WORK?	2 NO	281. LOCATION City or You	(Street and	1 Number or	Rural Rout	Number,		
ETED BY PHYSICIAN:	1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not independent determined 29a. CERTIFIER (Check only) 1 CERTIFYING PH	28e. DATE OF H (Month, Day) on 28a. PLACE OF building, e	NJURY , Year) INJURY — At horac, (Specify) my knowledge, de	me, farm, s	ury M street, fector	WORK? 1 YES , office	place, and du	28f. LOCATION City or You	m, State) and manne	or ne stated				
BE COMPLETED BY PHYSICIAN:	1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not independent determined 29a. CERTIFIER (Check only) 1 CERTIFYING PH	28e. DATE OF II (Month, De) 28a. PLACE OF building, e 1YSICIAN: To the best of n	NJURY , Year) INJURY — At horac, (Specify) my knowledge, de	me, farm, s	ury M street, fector	WORK? 1 YES , office o, deta and palon, death c	place, and dus	28f. LOCATION City or You a to the cause(a) a time, data and	and manne	or ne stated	cause(a) an			
E COMPLETED BY PHYSICIAN:	1 YES 2 NO 27. MANNER OF DEATH 1 Nstural	28e. DATE OF II (Month, Depon) 28e. PLACE OF building, e 11/SICIAN: To the best of m IINER: On the basis of axa	NJURY (, Year) INJURY — At horizontal city (Specify) my knowledge, de amination and/or i	me, farm, seth occuminvestigatio	URY M street, fectory of at the time	work? 1 YES , office o, data and pllon, death c	place, and dus	28f. LOCATION City or Tou a to the cause(a)	and manne	or ne stated	cause(a) an	nd manner ee s		
BE COMPLETED BY PHYSICIAN:	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation Investigati	28e. DATE OF II (Month, Depon) 28e. PLACE OF building, e 11 VSICIAN: To the best of m INNER: On the basis of axa	NJURY (, Year) INJURY — At horizontal city (Specify) my knowledge, de amination and/or i	me, farm, seth occuminvestigatio	URY M street, fectory of at the time	work? 1 YES , office o, data and pllon, death c	place, and dus	28f. LOCATION City or You a to the cause(a) time, data and i	and manner place, and	or ne stated	cause(a) an	nd manner ee s		
BE COMPLETED BY PHYSICIAN:	1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation Investigati	28e. DATE OF II (Month, De) 28a. PLACE OF building, e 1/SICIAN: To the best of n INER: On the basis of axa FIER WHO COMPLETED CAUSE 32. REGISTRAR	NJURY / At ho tc. (Specify) my knowledge, de amination and/or i C C C C C C C C C C C C C C C C C C	me, farm, seth occuminvestigatio	URY M street, fectory of at the time	work? 1 YES , office o, data and pllon, death c	place, and dus	28f. LOCATION City or You a to the cause(a) a time, data and	and manner place, and	or ne stated	cause(a) an	d manner ee a		



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 5- hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR 1 - STATE REGISTRAR

	nedio inan			ENIIF	ICAIL	. 01	DEA	111		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF MONTH	DEATN DA	NY.	YEAR	3. TIME OF DEATH
	KATHRYN ELIZAB								12	7		94	1:50 p m
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. le		IF UNDER	1 YEAR DAYS	HOURS	24 HRS. MIN.	7. DATE OF 1 (Month, De 10-22-	BIRTH by, Year)		8. BIRTHPLACE (State or Foreign Country) Maryland	
	213-74-8726 1 M 2 M F 89				A) 0777	-				-05			
œ	Chesapeake Manor Nursing Center				100		OR LOCATIO	ON OF DE	ATH		141	9c. COUNTY OF OEATH	
DIRECTOR	RESIDENCE OF DECEDENT				Arn	old					Anne	2 Aru	ındel
SE	10e. STATE 10b. COUNTY	Y		10c. CIT	Y, TOWN O	R LOCAT	TION						10d. INSIDE CITY
ā	Maryland Anne Arundel				nnap	olis	5						LIMITS? 1 YES 2 A NO
AL	10e. STREET AND NUMBER					101	. ZIP CODI	E	16g. CITIZEN OF WHAT CO			WHAT COUNTRY?	
FUNERAL	921 Mastline Dr.					2	21401			U.S.A.			
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN FORCES? 1 Name Manufact 1 YES									or No-	14, RACI	E American Indian, k, White, etc.	
BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE W					2 (2) NO			it, artis		Spec	offy:
	15. DECEDENT'S EDU	CATION	Liste Di	ECEDENT'S	USUAL OF	NO IDATI	201		David visi			Whi	te
H	(Specify only highest grade Elementary/Secondary (0-12)	completed)	(0	Give kind of a	work done o	during mo	at of working	ng	16B. KIP	ID OF BU	SINESS/INI	JUSTRY	
PLI	8 Vrs	College (t-4 or 5 -	·	me Ma	ker				0.	vn Ho	nme		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)	_ <u>:</u>		16. MOTHER'S NAMI									
BE C	Bernard J. Schmi	.dt					Mary	Hel	en McI	ona.	Ld		
	19a. INFORMANT'S NAME (Type/Print)	·	19	b. MAILING	ADDRESS	(Street a	nd Number	or Rural F	Route Number, (City or Tow	n, State, Zij	Code)	
2	Mary Ann Degenhar	rd		921 M	astl	ine	Dr.	Anna	polis	, Md.	214	01	
	20a, METHOD OF DISPOSITION 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Rem	ovel from State	20b. PLACE			ITION (Na	ime of		DATE	20c. LO	CATION —	City or To	own, State
	4 Donation 6 Other (Specify)	72 77 12 12	Garde	ematory or o ens o	f Fa	ith			12-10	Ovei	clea.	Md.	
1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE /	of				ND ADDRES	SS OF FAC	CILITY				
	16 6		191		10	ck '. 50 \	lowso York	n Fu	meral Towsor	Home	, In	204	
	23. PART I. Enter the diseases, or o	complications that	t caused the d	eeth. Do r	not enter	the mo	de of dyl	ing, auci	n aa cardlec	or reapl	ratory an	reat,	Approximate
	ehock, or heert fellure. IMMEDIATE CAUSE (Finel	Liet only one cau	se on aech lin	e .									Interval Between Onset and Death
	disease or condition resulting in death)												
Z	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (Disease or Injury)												
Ĕ	If any, leading to immediate cause. Enter UNDERLYING	DUE TO	OH AS A CONSE	QUENCE O	F):		A.	00	··				
CERTIFICATION	CAUSE (Diseese or Injury	DUE TO	OR AS A CONSE	OLIENCE O	and a	2V	re	الكاف					
Ē	that initieted events resulting in death) LAST		(OIL NO H CONCL	OOLHOL O	,,.								i
E		d											
	PART II. Other eignificent condition	e contributing to	death but not	reculting	In the un	derlying	g ceuse ç	given in	Part I. 24	PERFOR		24b	. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO
EDICAL									10		NO	_	COMPLETION OF CAUSE OF DEATH?
M													1 TES 2 NO
ż	DID TOBACCO USE CONT	RIBUTE TO CA	USE OF DEA	ATH YE	1 🗆 8	10 C	LUNC	ERTAIN	1 🗆 📗				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLA	CE OF DEA	OTHER								
YSI	1 YES 2 NO	1 Inpatient 2		3 🗆 DOA			e 5 □ Re	sidence	6 Other (Sp	ecify)			
H	27. MANNER OF DEATH t Natural 5 Pending	28a. DATE OF (Month, D		26b. TIM	E OF URY		RK?		28d. DESCRI	BE NOW I	NJURY OC	CURED	
B	2 Accident Investigation				М	1 🗆 '		NO					
	3 Suicide 8 Could not be 4 Nomicide determined	28e. PLACE O building,	F INJURY — At he etc. (Specify)	ome, farm, i	street, facto	ory, offic	•			N (Street a own, State)	ind Number	or Rural I	Route Number,
<u>u</u>				_									
MPI	(Check only	CIAN: To the beat of											
MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time,								time, date and	plece, en	d due to th	te ceuse(d	e) end manner ee stated.	
8	296. SIGNATURE AND TITLE OF CERTIFIER	Atta	1. 0	1)	g- ,		29c. LICE	ENSE NUM	IBER		29d. DAT	E SIGNED	(Month, Day, Year)
2	30 NAME AND ADDRESS OF STREET	- Magain	and a	VUC	OV			レス	1684			12-	10-19
- 1	30. NAME AND ADDRESS OF PERSON WN								0 6	9			
	31 DATE ENFER (MOURE DOWN MOON)		ne M.D.	T000	Rich	nie	High	way	,170	210	61	`	
31. DATE-FILED (MONITO DOS 1981) 32. AEGISTRAN'S SIGNATURE 34. AEGISTRAN'S SIGNATURE ACTUALLY OF MUNICIPAL PROPERTY.													

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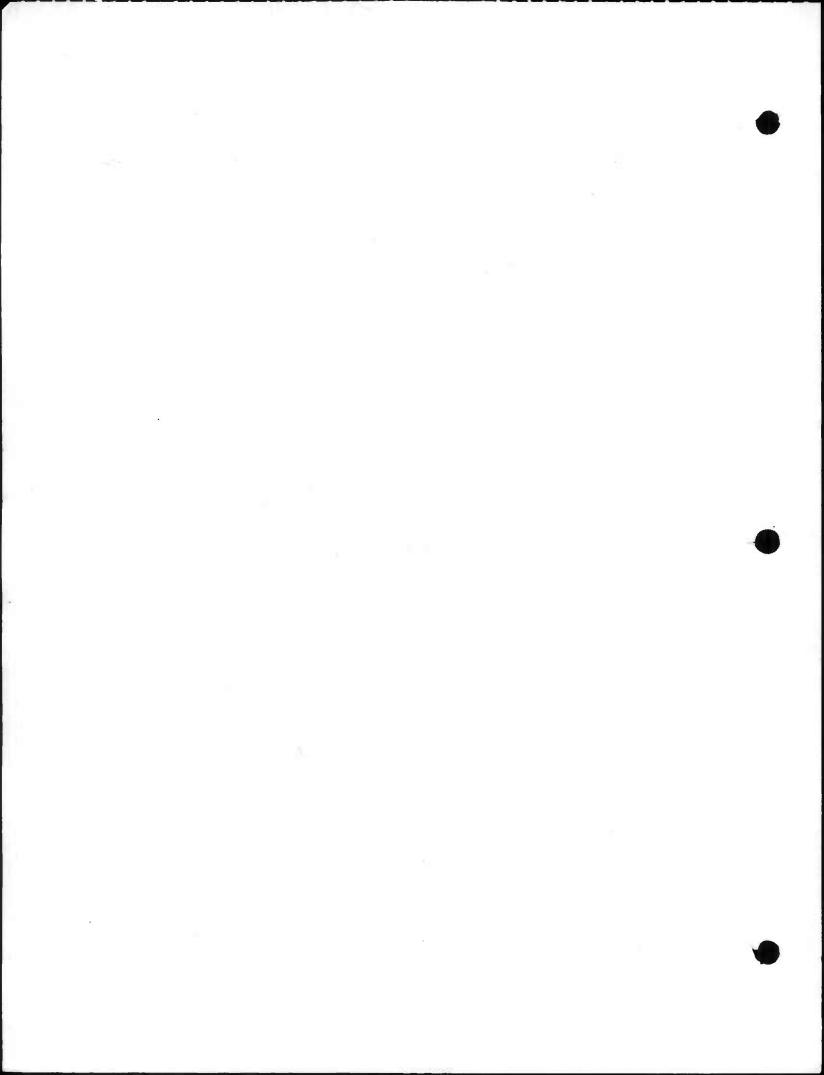
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THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within exhours after death. Page 6 may be retained by the hospita	THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached 1	lied within 70 hours offer death with the State Deat of Health and Mental Hunjane prior to harial premation or remove
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	_	REGISTRAR			CERTIFIC	ATE (OF DEATH	REG. N	0.	
		1. DECEDENT'S NAME (First, Middle	a, Last)		_			2. DATE OF DEATH		3. TIME OF OEATH
		DOUGLAS HAI	G SANDS					MONTH 12	13 94	YEAR 5:05 A M
		4. SOCIAL SECURITY NUMBER	5. SEX 6.	AGE (In yn	s. last birthday)	F UNDER 1 YE	AR IF UNDER 24 HRS.			BIRTNPLACE (State or Foreign
29		215-05-6768	1 🔀 M 2 🗆 F	78	YRS.	ONTHS DA	YS NOURS MIN.	Month, Day, Year) SEPT. 9,	1916	MARYLAND
3 should	~	9e. FACILITY NAME (If not inatitution	SC CC CC CC CC CC CC CC CC CC CC CC CC C			b. CITY, TO	WN OR LOCATION OF DE			Y OF OEATH
1, 2, 3	DIRECTOR	Greater Balt	imore Medical	Cen	ter !	[owso	<u>n</u>		Balt	timore
	1	10e. STATE 10b.	COUNTY		10c. CITY, 1	OWN OR L	OCATION			10d. INSIDE CITY LIMITS?
permit. Pages		MARYLAND	BALTIMORE		TOW:	SON				1 YES 2 XNO
	3AL	10e. STREET AND NUMBER					10f. ZIP CODE		10g. CITIZE	N OF WHAT COUNTRY?
020 physician. buñal-transit	FUNER	800 SOUTHERLY					21286			USA
120 hysici urial-i	F	11. MARITAL STATUS 1 Never Merried 2 K Merrie	12. WAS DECEDENT E FORCES? 1	YES 2	NO	If yes	DECENDENT OF HISPAN I, specify Cuban, Mexicon	, Puerto Rican, etc.)	es or No- 14	I. RACE — American Indian, Black, White, etc.
9 2	ВУ	3 Wildowed 4 Divorced	IF YES, GIVE WAR	OR DATES	I	10	YES 2 NO Specify	- 542 0.445-5		Specify WHITE
1215 r attend use as	TED	15. DECEDENT (Specify only highe	'S EDUCATION st grade completed)	16a	. DECEDENT'S US	done durin	PATION g most of working	16b. KIND OF B	USINESS/INDUS	TRY
21 oktal or d for u	COMPLET	Elementary/Secondary (0-12)	College (1-6 or 5+)		Ille. Do NOT use r	etired.)	TRACTOR		NSTRUC'	TION
AND 2. The hospital of detached for once.	M	17. FATHER'S NAME (First, Middle, L			GENERA			AE (First, Middle, Maide		1101
MARYLAND retained by the hospit 5 should be detached motified at once.	Ш	WILLIAM	н.		SANDS		HANNAH	L.	in Surrieme)	SIMPSON
MAR retained 5 should notified	00	19e. INFORMANT'S NAME (Type/Pris	nt)		19b. MAILING AL	DRESS (Str	eet and Number or Rural R	oute Number, City or To	wn. State. Zio Co	ode)
M. M. M. M. M. M. M. M. M. M. M. M. M. M	2	MRS. JANICE L.	SANDS		800 SOT	JTHER	LY ROAD SU	ITE 310 T	OWSON,	MD. 21286
RE, may be		20e. METHOD OF DISPOSITION X Burlel 2 ☐ Cremetion 3	Removal from State		CEANDDATEOF		N (Name of	DATE 20c. L	OCATION - CI	y or Town, State
MORI ge 6 may Sirector, p		4 Donation 5 Other (Specif	y)	WOO	DLAWN C			2/17/94 B	ALTIMO	RE, MD.
BALTIMORE, ter death. Page 6 may by the funeral director, page wal.		21. SIGNATURE OF FUNERAL SEIN	NCE LICENSIE	7			E AND ADDRESS OF FAC		_	
BAI er dea val.		Macke	els buot	2		105	ck Towson E 50 York Rd.	Towson,	ome, In Md. 21	204
B nours after d in by the or removal		23. PART I. Enter the disease shock, or heart for	a, or complications that callure. List only one cause	aused the	death. Do not	enter the	mode of dying, such	as cardiac or res	piretory arres	t, Approximate
filled in on, or re		IMMEDIATE CAUSE (Final	mule. List only one cause	A each	illie.					Onset and Death
± ≥ te		disease or condition reaulting in death)	. Deer	21	MI					
68760, secuted within Earl and completely filled burial, cremation,			DUE TO (OF	R AS A COI	NSEQUENCE OF):					
RDS, P.O. BOX 6876 at the death certificate be executed by the attending physician and com and Mental Hygiene prior to burial, ay Injury, or other traumatic ev	CERTIFICATION	Sequentially list conditions,	b. DUE TO (OF	AS A COL	NSEQUENCE OF):					
BOX cate be en hysician to prior to	SAT	If any, leading to immediate cause. Enter UNDERLYING	AR	-11	()					
O. E. rtifica rtifica phy piene	臣	CAUSE (Disease or Injury that initiated events	DUE TO (OF	R AS A CO	NSEQUENCE OF):					
P.O ath cert tending all Hygie	E	resulting in death) LAST	d							
OS, he dea Ment Ment		PART II. Other significant con	nditions contributing to de	ath but n	ot resulting in	he under	lying cause given in	Part I. 24a, WAS A	N AUTOPSY	24b. WERE AUTOPSY FINDINGS
ORDS, s that the deal ned by the atl lith and Menta any injury,	DICAL	CNA					act some will no	PERF	ORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
Ulires Signe Healt Dws a	MED							1 □ YES	ZKANO	OF DEATH? 1 YES 2 NO
F VITAL RECORDS, P.O. BOX 68760, SICIAN: The law requires that the death certificate be executed with certificate has been signed by the attending physician and complete in the State Dept. of Health and Mental Hygiene prior to burial, crem.	ž	DID TOBACCO USE C	ONTRIBUTE TO CAUS	SE OF D	EATH YES	□ NO	☐ UNCERTAIN			
N: The la ficate has State De Item 2	SICIAN:	25. WAS CASE REFERRED TO MED EXAMINER?			LACE OF DEATH	Check only				
VIT NAN: TI rifficate he State or iter	>	1 D YES 2 NO	1 Inpatient 2 El	R/Outpatier	H 3 000A 4	THER:	Nome 5 Residence	Other (Specify)		
O 축 등 등 호	PH	27. MANNED OF DEATN 1 Natural 5 Pendin	26e. DATE OF IN. (Month, Day,	JURY Ybar)	26b. TIME O	Υ	INJURY AT WORK?	28d, OEŞCRIBE HOW	INJURY OCCU	RED
ON DING P After death	ВУ	2 Accident Investig	pation	HIDV A	it home, ferm, stre		YES 2 NO	201 1 2 2 1 2 2 1 2 2		
DIVISION OF VITA OR ATTENDING PHYSICIAN: The ORECTOR: After this certificate h hours after death with the State D Item 28 is marked, or Item	TED	3 Suicide 8 Could 4 Homicide determ	building, atc	(Specify)	it nome, with, acre	er, rectory,	onice	281, LOCATION (Stree City or Town, Stat		Hural Houte Number,
DOI NOUT THE	ш	290. CERTIFIER 1 CERTIFYING	PNYSICIAN: To the beat of my	knowledou	, death occurred	it the time	date and place, and disc	in the operate's and —	enner en chita f	
HOSPITAL FUNERAL Within 72 I	OMPL									Ceuse(s) end menner es stated.
TO THE HOSPITAL TO THE FUNERAL De filed within 72	E CO	296. SIGNATURE AND TITLE OF CE	0		0. 0		29c. LICENSE NUM			SIGNED (Month, Day, Year)
MPOR	10 B	NVuen	A she	V.	Ma		204	461	1/2	7-13-94
,5	F	30. NAME AND ADDRESS OF PERS								
\			ohen 201 E. U			cwy S	uite 501		<u>. </u>	
		31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S	SIGNATUR	14					

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 34 frours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 75 bunish the State Dept. of health and Mental Hyghere prior bunial corresponding to returned. Or enhance the property of the page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 75 bunish the page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 75 bunish the page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 75 bunish the page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 75 bunish the page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 75 bunish the page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be detached for use 2, 4, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5, 5,	The control of the co
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	1 - STATE OF MARYLANI REGISTRAR	D / DEPAR CERTIF	TMENT	OF H	EALTH AND I	MENTAL HYGIENE REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF OEATH		3. TIME OF DEATH	
- 1	Ruth C. Schimminger	December 14		7:45 A M					
		The first property and the state of the stat						HPLACE (State or Foreign	
	233-44-5046 1 M 2 XF 64	YRS.	MONTHS	DAYS	HOURS MIN.	February 2,		aryland	
~	9e. FACILITY NAME (if not institution, give street end number)		9b. CITY,	TOWN C	R LOCATION OF DE	АТН	9c. COUNTY OF	DEATH	
DIRECTOR	123 S. Carrollton Ave.		В	alt	more			141	
EC	10a. STATE 10b. COUNTY	10c. CIT	Y, TOWN O	R LOCAT	ION			10d. INSIDE CITY	
DIR	Md.	F	Balti	more	3			LIMITS?	
	10e. STREET AND NUMBER		JULUI	_	ZIP CODE		WHAT COUNTRY?		
FUNERAL	123 S. Carrollton Ave.			1	21223	3	JSA		
5	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S FORCES? 1 YES 2		13. V	WAS DEC	ENDENT OF HISPAN	IC ORIGIN? (Specify Yee o	or No — 14. RAC	E — American Indien,	
BY	1 Never Merried 2 Merried 3 Wildowed 4 Divorced FORCES 1 YES 2 IF YES, GIVE WAR OR DATES		1	YES TES	2/ NO Specify	n, Puerto Ricen, etc.)	Spec		
	Λ Ι	. DECEDENT'S	USUAL OF	OUDATIO				white	
	(Specify only highest grade completed)	(Give kind of v	vork done a	luring mo	st of working	16b. KIND OF BUSH	NESS/INDUSTRY		
7	Elementary/Secondary (0-12) College (1-4 or 5+)	Nursi	ng A	ssis	stant	Bay Mo	eadows N	I. н.	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Malden St			
BE	George Kerns				Eva E	Biederman			
2	19a, INFORMANT'S NAME (Type/Print)					loute Number, City or Town,			
	Judy Cole					alto., Md. 21223			
	20e. METHOD OF DISPOSITION 1 © Burlet 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE of Disposition (Name of center) 20b. PLACE AND DATE of Disposition (Name of center) 20b. PLACE AND DATE of Disposition (Name of center) 20c. LOCATION — City or Town, State 21. SIONATURE OF SHAPPING SERVICE (Specify) 21. SIONATURE OF SHAPPING SERVICE (Specify)								
	21. SIONATURE OF FUNERAL SERVICE HERE	o Snep			D ADDRESS OF FA	12/19 EII:	icott ()	ty, Md.	
	- XL					an Funeral	Home of	Elk Inc.	
-	23. PART I. Enter the diseases, or complications that caused the	- dW B	156	95 N	lain St	Flkridge	Md 21	227	
	shock, Dr heart fellure. Liet pnly one ceuse on eech	line.				,	otory errest,	Approximate interval Between Onset and Death	
	disease or condition resulting in death) e. Due to (OR AS A CONSEQUENCE OF):								
_	DUE TO (OR AS A CONSEQUENCE OF):								
흔	Sequentielly list conditions, If any, leading to immediate	NSEQUENCE OF	7:						
<u>8</u>	CAUSE (Disease or injury								
٤	thet initiated events resulting in death) LAST	NSEQUENCE OF):						
CERTIFICATION	d								
7	PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PROPRIED? AMILABLE PRIOR TO								
PHYSICIAN: MEDIC	14 tastalu Co or	Cusc	120	Loca	4+ ye	1 VES 2		COMPLETION OF CAUSE OF DEATH?	
M	DID TODA GGO LIGA GOLUMNIA TO CALLED			_			`	1 TYES 2 NO	
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF D	PLACE OF DEAT	S D N		UNCERTAIN	1 🗆]		~	
띯	EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Outpatien		OTHER	:	J.				
Ĕ	27. MANNER OF DEATH 280. OATE OF INJURY	28b. TIM(4 Nura	26c. INJU	IRY AT	6 Other (Specify) 26d. DESCRIBE HOW INJ	IURY OCCURED		
BY P	1 Natural 5 Pending (Month, Day, Year)	INJ	URY M	1 Y	RK? ES 2 NO				
	2 Accident investigation 3 Suicide 6 Could not be building, stc. (Specify)	it home, farm, s	treet, facto	ry, office		28f. LOCATION (Street end	d Number or Rural I	Route Number,	
COMPLETED	4 Homicide determined					City or Town, State)			
ᆲ	29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge								
Š	One) 2 MEDICAL EXAMINER: On the beele of examination and	d/or investigation	n, In my op	olnlon, de	ath occured at the	time, date end place, end	due to the ceuse(e	e) end menner ee stated,	
BE	290-SIGNATURE AND TITLE OF CERTIFIER)~~			29c. LICENSE NUN	BER :	29d. DATE SIGNED	(Moren, Dec Year)	
ဂ္	HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	OTEM 27 Car	Orint)		1/10	771	- 14)	174	
	(ussell a, De lucar 300)) 53	Ja201	205 5	t, Ral	tomen.	0. 713	061	
	31, DATE EILED (Month, Day, Year) DE C1 6 1994 32, REGISTRAR'S SIGNATURE A CONTROL OF THE PROPERTY OF THE P	RE							
	1984 Jahr Walter Can	611							



30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Eastern

Block

32. REGISTRATE SIGNATURE
Julia Sturbles Randall

Health

Ferraco

ictor

31. DATE FILED (Month, Day, Year)

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF I		DEPAR ERTIF					MENTAL HYGIEI REG. NO			
	1. DECEDENT'S NAME (First, Middle, Last)	Robert	Louis S	Shriv	er				2. DATE OF DEATH MONTH DECEMBER	DAY	YEAR 1994	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER				7. DATE OF BIRTH	2 1-	<u>, , , , , , , , , , , , , , , , , , , </u>	PLACE (State or Foreign				
	215-09-8632	1 X M 2 - F	77	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	017	Countr	γ)
	9a. FACILITY NAME (If not institution, give s		7.7		9h CITY	Y TOWN C	DR LOCAT	ION OF DE	01/04/1		NTY OF D	ryland
<u>c</u>	2718 Plainfield	•					unda		LAIN		alti	
	RESIDENCE OF DECEDENT					L	uiluo	ITK		_ E	атсп	IIDTE
DIRECTOR	Maryland Baltimore			10c. CITY, TOWN OR LOCATION					dalk			10d. INSIDE CITY LIMITS? 1 YES 2 X NO
	10e. STREET AND NUMBER	Dalein	010			100	. ZIP COD		MALIK	140- 017	17511 05 11	HAT COUNTRY?
FUNERAL	2718 Plainfield	Road					. ZIF COD	2122	22			d States
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF FORCES? 1 News Mariad 2XX Married FORCES? 1 News Mariad 2XX Married FORCES?						OF HISPAN	NIC ORIGIN? (Specity Von, Puerto Ricen, etc.)	s or No—	14. RACE	- American Indian, White, etc.		
B	1 Never Married 2XXMarried 3 Widowed 4 Divorced	IF YES, GIVE V						Specify			Specif	
0	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refired.) Warrant Officer Chief Warrent Officer U.S. Navy							DUSTRY				
1	12 Years		Ch	ief ₹	varre	nt ()ffic	ier	U.S.	Navy	7	
COMPLET	17. FATHER'S NAME (First, Middle, Last)						16. MOT	HER'S NA	ME (First, Middle, Maide	Sumame)		-
l w l	Andrew Shriver						Ar	nie	Tyler			
0 8	19a. INFORMANT'S NAME (Type/Print)		19	b. MAILING	ADDRES	S (Street a	nd Numbe	r or Rural I	Route Number, City or To	vn, State, Zij	Code)	
F	Robert L. Shriver, Jr. 4117 Beechwood Road Dundalk, Maryland 21222											
	20a. METHOD OF DISPOSITION 1 ★ Burial 2 ☐ Cremation 3 ☐ Rame		20b. PLACE	AND DATE	OF DISPOS	SITION/Na	me of		DATE 20c. L	OCATION —	City or To	wn, Stata
1	4 Donation 5 Other (Specify)	over from State	Sacr	ed Ht	ther place)	Jes	sus (Cem. 1	12/16/94	Dund	lalk,	Maryland
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEL /	1//		22.	NAME AN	ID ADDRE	SS OF FA	CILITY			
	Cherl W	ti	4/						neral Hom ve. Dunda			
	23. PART i. Enter the diseases, pro	omplications the	ceueed the de	esth. Do	not enter	the mo	de of dy	ing, suci	h es cerdiec or resp	iratory ar	rest,	Approximata
1 1	ehock, pr heert faliure. List only one eause on each line. IMMEDIATE CAUSE (Finsi								Onset and Death			
						-						minutes
	disease or condition reaulting in deeth) e. Repiratory area minute DUE TO (OR AS A CONSEQUENCE OF):							11.14.016				
z	sequentially list conditions to makstatic adenocarcinoma of lung amonth								2 months			
RTIFICATION	Sequentisity list conditiona, if any, leeding to immediate	DUE TO	(OR AS A CONSE	OUENCE O	F):							
S	cause. Enter UNDERLYING CAUSE (Disease or injury	B										
띨	thet initieted events	DUE TO	(OR AS A CONSE	OUENCE O	F):							
Ε	resulting in death) LAST	i										
G	PART ii Other eignificent condition	a aantalbutlaa ta	death had and	an andalas -								
N N	PART II. Other aignificant condition	s contributing to	deeth but not	gniyiuser	in the ur	nderiying	ceuse	given in		RMED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDICA									1 YES	2 DNO		COMPLETION OF CAUSE DF DEATH?
×					_				_			1 TYES 2 NO
ä	DID TOBACCO USE CONTE	RIBUTE TO CA	USE OF DEA	TH Y	S 🔲 I	NO [UNC	ERTAIN	N 🔯			
HYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLA	CE OF DEA	OTHER							
S	1 TES 2 KNO	1 Inpatient 2	ER/Outpatient 3	□ DOA			a 5 € R	sidenca	6 Other (Specify)			
H	27. MANNER OF DEATH	28a. DATE OF (Month, D	INJURY ay, Year)	28b. TIM	E DF	28c. INJI WO	URY AT RK?		28d. DESCRIBE HOW	INJURY OC	CURED	
8	1 Natural 5 Pending 2 Accident Investigation				М	1 🗌 Y		NO				
ED	3 Suicida 6 Could not be	28a. PLACE O building,	F INJURY — Al ho atc. (Specify)	oma, larm,	street, fact	tory, office			281. LOCATION (Street City or Town, State	and Number	or Rural A	oute Number,
H.	4 Homicide detarmined								ony or tonn, diane	,		
급	29a. CERTIFIER (Check only	CIAN: To the beat of	my knowledge, de	eth occurr	ed at the t	lme, date	and placa	, and due	to the cause(s) and me	nner as ata	ted.	
COMPL	one) 2 MEDICAL EXAMINE											and manner as stated.
Ŭ	29b. SIGNATURE AND TITLE OF CERTIFIER					T	29c. LICI	ENSE NUM	ABER	29d, DAT	E SIGNED	(Month, Day, Year)
<u> </u>	Vietro Forms						01	460	0 (0.4	- Comed	4, 1994
일	30. NAME AND ADDRESS OF PERSON WHO		E OF DEATH ATE	14 an (T	0-1-11		U	100	1 70	. 0	-C. 1	7 1714

Center, 502 Eastern Blue

Baltimemo

MESIE

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an intermed to the flow of the intermed of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

_	FOR STATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
-	REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	STATE STATE CF MANYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 3. TIME OF DEATH									
	VIOLA SNYDER DEC. 13, 1994 2:20 a	м								
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthdey) FUNDER 1 YEAR FUNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign Months DAY8 Hours Min. (Mogth, Day April DAY8 April DAY8 April DAY8									
	379-38-4077 TIM 2 KF 77 YAS. OCt. 10, 1917 Pennsylvani	.a								
~	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH									
DIRECTOR	NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE A.A. COUNTY	4								
REC	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS?									
	MD Anne Arundel Odenton 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1									
FUNERAL	106. STREET AND NUMBER 107. STREET AND NUMBER 108. CITIZEN OF WHAT COUNTRY? USA USA									
B	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specifly Yes or No— If yes, specifly Cuban, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 15. WAS DECEDENT OF HISPANIC ORIGIN? (Specifly Yes or No— If yes, specifly Cuban, Maxican, Puerto Rican, etc.) 16. WAS DECEDENT OF HISPANIC ORIGIN? (Specifly Yes or No— If yes, specifly Cuban, Maxican, Puerto Rican, etc.) 17. WAS DECEDENT OF HISPANIC ORIGIN? (Specifly Yes or No— If yes, specifly Cuban, Maxican, Puerto Rican, etc.) 18. WAS DECEDENT OF HISPANIC ORIGIN? (Specifly Yes or No— If yes, specifly Cuban, Maxican, Puerto Rican, etc.)									
E	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working	\neg								
9	Elementary/Secondary (0-12) College (1-4 or 5+) House or retired.)	- 1								
COMPLETED	0	4								
BE CC	17. FATHER'S NAME (First, Middle, Last) Frank Beadle 18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Unknown	ľ								
2	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
-	Elmer C. Snyder 1243 Scotts Manor Court, Odenton, MD 21113	<u>}</u>								
	20a. METHOD OF DISPOSITION 1 % Burdel 2 Cremetion 3 Removal from State 20b. PLACE AND DATEOF DISPOSITION (Name of Venture State Venture of Venture State Venture of Venture State Venture of Venture									
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY	一								
	Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401	. 1								
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate									
	shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Stat w Epileplicus									
_	DUE TO (OR AS A CONSCOURNE OF):									
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CALLEE (Disease or lating)									
S	CHOSE (Disease of Injury	_								
FI	that initiated events resulting in death) LAST									
2	PART ii. Other aignificant conditions contributing to death but not resulting in the underlying causa given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
ICAL	PAH1 II. Other aignificant conditions contributing to death but not resulting in the underlying causa given in Part i. 24e. WAS AN AUTOPSY PREFORMED? 24b. WERE AUTOPSY FINDING AMILABLE PRIOR TO COMPLETION OF CAUSE									
MED	1 YES 2 NO DF DEATH?									
2	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	\exists								
YSIC	HOSPITAL: 1 VES 2 NO 1 Impetiant 2 ER/Outpetiant 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									
PH	27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY AT WORK? M 1 ∀ES 2 NO	\neg								
D BY	2 Accident 3 Suicide 6 Could not be building, etc. (Specify) 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, Street)	\dashv								
COMPLETED	4 nomicide detarmined									
MPL	29a. CERTIFIER Check only DESTRICTION To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(a) and manner as stated.									
CO	2 MEDICAL EXAMINER: Dn the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.									
M.	The SH NATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)									
5	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	\dashv								
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	DEC 16 1994 July 2000									
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

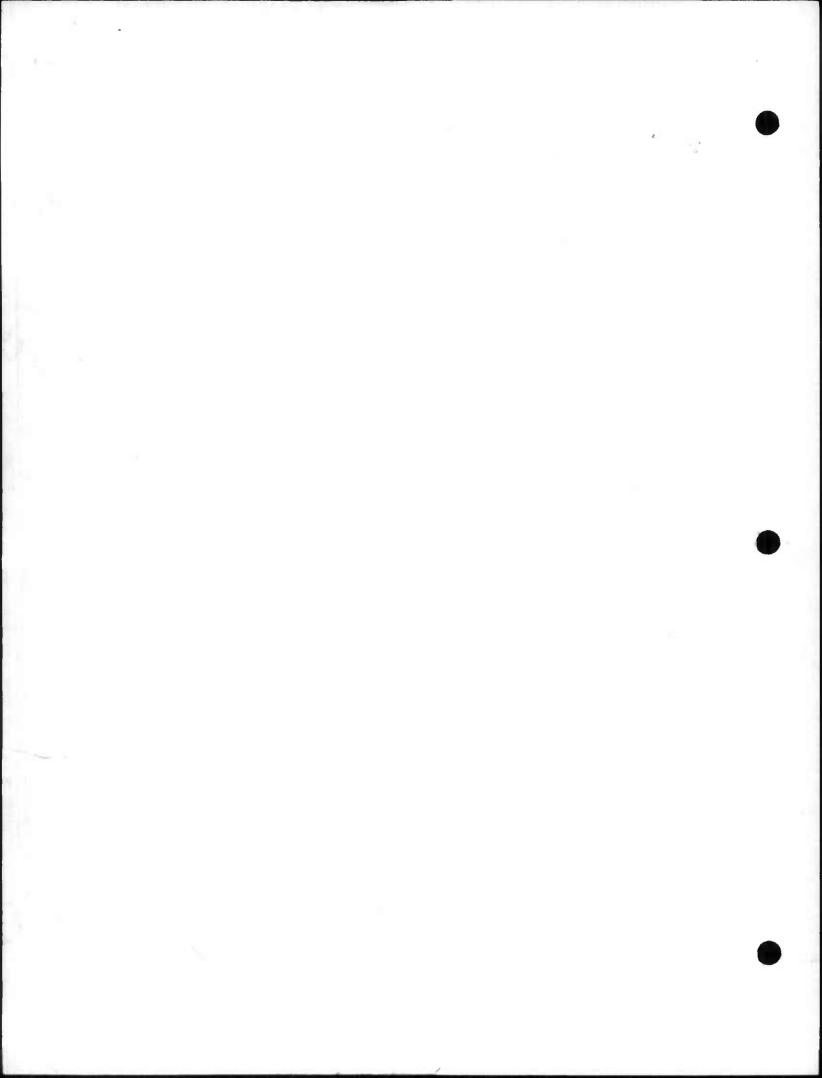
	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTM CERTIFIC				YGIENE EG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last) Jonathan Macki	intosh Sma	11			2. DATE OF D		94 ^{YEAR}	3. TIME OF DEATH 3:00a M	
	4. SOCIAL SECURITY NUMBER 128-28-7462	8-28-7462 1 XM 2 □ F 56 YRS. MONTHS				IF UNDER 24 HRS. 7. DATE OF BIRTH 0. BIRTHPLACE (State or Country) OCT. 25, 1938 New York			HDI ACE (State or Engine	
FOR	9s. FACILITY NAME (If not institution, give st Anne Arundel N			Annapo	lis	EATH	9c. C0	DUNTY OF D		
DIRECTOR	10 METATE 106. COUNTY Anne	Arundel		OWN OR LOCAT					10d. INSIDE CITY LIMITS? 1 XYES 2 NO	
FUNERAL	917 Judge Court E.				20778		10g. C	10g. CITIZEN OF WHAT COUNTRY? USA		
B⊀	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IF FORCES? 1 XYES IF YES, GIVE WAR OR D	2 NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- If yea, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 YES 2 NO Specify:			14. RACE — American Indien, Black, White, etc. Specify: White			
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12)	CATION completed) College (1-4 or 5+)	16a. DECEDENT'S USI (Give kind of work life. Do NOT use re Sales Ac	done during most of working lined.)						
	17. FATHER'S NAME (First, Middle, Last) Edgar Parker S	mall		-	18. MOTHER'S NA	Insurance 18. MOTNER'S NAME (First, Middle, Maiden Surname) Muriel Cowing Mackintosh				
TO BE	190. INFORMANT'S NAME (Type/Print) Sally Yvonne S	mall	196. MAILING AD 917 Ju	oness (Street o	nd Number or Rural	Route Number, Ci	ty or Town, State,	Zip Code)		
	Sally Yvonne Small 20e. METHOD OF DISPOSITION 1 Burfel 2 Octometion 3 Removal from State 20b. PLACE AND DATE of DISPOSITION (Name of Memory) 20c. DATE 20c. LOCATION - City or Town, State 12/15 Baltimore, MD									
	21. SIGNATURE OF FUNEBAL SURVICE LIC			22. NAME AN Harde	sty Fu	neral	Home,	P.A		
CERTIFICATION	iMMEDIATE CAUSE (Finel disesse or condition resulting in death)	B. DUE TO (OR AS A	the desth. Do not ech line. Part End CONSEQUENCE OF): CONSEQUENCE OF):	enter the mo	de of dying, auc	h as cardlac d	or respiratory (irrest,	Approximate interval Between Onset and Death	
PHYSICIAN: MEDICAL CI	CI Yeel Clarker 1 20 and Clarker D2 PERFORMED2 1 TYES 2 INO							D. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO		
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? Continuous									
	1 YES 2 NO 27. MANNER OF DEATH Neturel 5 Pending	1 Inpatient 2 ER/Outp 28e. DATE OF INJURY (Month, Day, Yeer)		Nursing Home	RK?		cify) E HOW INJURY O	CCURED		
TED BY	2 Accident Investigation Inves						per or Rural	Route Number,		
COMPLETED	29e. CERTIFIER (Check only one) 29e. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. 2									
8	29b. SIGNATURE AND TITLE OF DESTITER					29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day, Year)				
2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LIST D WARD 1833 - FOREST DR ANNAPULT								3 MO 2 1901		
	DEC16 1994	32. REGISTRAR'S SIGN			/		7			

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FOR STATE REGISTRAR CERTIFICATE OF DEATH DECEDENT'S NAME (First, Middle, Last 2. DATE OF DEATH
MONTH
DECEMBER 3. TIME OF DEATH 125pm ROEDER SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 12/13/1926 IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS HOURS 223-28-8840 1 € M 2 🗌 F 68 YRS. Minnesota Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Good Samaritan Hospital Baltimore RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Baltimore 1 YES 2 X NO permit. 100. STREET AND NUMBER 2906 Scherer Avenue FUNERAL 10g. CITIZEN OF WHAT COUNTRY? U.S.A 21234 the funeral director, page 5 should be detached for use as the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician, 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 \(\frac{1}{2} \) YES 2 \(\text{NO} \) NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-11. MARITAL STATUS X

1 Never Married 2 Merried 14. RACE — American indian, Black, White, etc. It yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced White COMPLETED 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5 +) 12 Crane Operator C J Langnfelder Co. 17. FATHER'S NAME (First, Middle, Last)
Peter A. Schroeder 18. MOTHER'S NAME (First Middle, M Ruth A Nelson 70 BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Jean Schroeder 2906 Scherer Avenue Baltimore, Maryland 21234 9 2m. METHOD OF DISPOSITION
1 ☐ Burlel 2 ☐ Cremetlon 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE must Commetery, crematory, or other place)
Dulaney Valley Memorial 4 Donation 5 Other (Specify) 12/17/94 Balto. Md 22. NAME AND ADDRESS OF FACILITY The Dippel Funeral Home examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE martin 7110 Belair Road Balto. MD 21206 medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, been signed by the attending physician and completely filled in by t, of Health and Mental Hygiene prior to burial, cremation, or remo shock, or heart failura. List only one cause on each line. Interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition_ taleux Legarany event, resulting in death) DUE,TO (OR AS A CONSEQUENCE OF): the death certificate be executed FULLOIM traumatic CERTIFICATION Sequentially list conditions, if sny, lasding to immediate NSEQUENCE OF): cause. Enter UNDERLYING CLEAKERYA CAUSE (Disease or injury other that initiated events resulting in death) LAST 6 PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO that shows any COMPLETION OF CAUSE 1 ☐ YES 2 ☐ NO 1 | YES 2 | NO PHYSICIAN: DR ATTENDING PHYSICIAN: The law Dept. 23 TO THE HOSPITAL DR ATTENDING PHYSICIAN; The law TO THE FUNERAL DIRECTOR: After this certificate has the filed within 72 hours after death with the State Dept IMPORTANT: If Nem 28 is marked, or Item 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: Inpatient 3 PER/Outpatient 3 DOA 1 YES 2 NO 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER, OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1. Natural Pending 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, term, street, factory, office building. etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) BE-COMPLETED 4 Homicide determined 29a CENTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(e) end manner se stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated. TORE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER SECUNIER TE Ween 1128717 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2 41279 Rash 32 MEGISTRAR'S PENATURE DEC16 1994



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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MA	BALTIMORE, MARYLAND 21215-0020
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within nours after death. Page 6 may be retained by the hospital or attending physician.	be retained by the hospital or attending physician.
TO THE FUNERAL CHARCHAR State Dept the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	je 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should
IMPORTAM: Little 28% marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	e notified at once.

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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	FOR 1 - STATE REGISTRAR	STATE OF MARY					EALTH AN DEATH	D M	ENTAL HYGIEN REG. NO	_		
	1. DECEDENT'S NAME (First, Middle, Last)	0							2. DATE OF DEATH			3. TIME OF OEATH
	SEYMOUR SILVERSTEIN					V			December	8 /4	994	0210 A
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AG	GE (In yrs. las	l birthday)	IF UNDER	1 YEAR	IF UNDER 24 H		7. DATE OF BIRTH	•	8. BIRTH	PLACE (State or Foreign
	084-07-2914	1 ²²³ M 2 □ F	76	YRS.	MONTHS	DAYS	HOURS MI	N	June 25,	1918	New	York
	9a. FACILITY NAME (If not institution, give s	treet and number)			9b. CITY,	TOWN C	R LOCATION O	_		9c. COU	NTY OF D	EATH
DIRECTOR	Washington Adver	tist Hospit	tal		Та	koma	a Park			Mor	itgon	ery
₩	10a. STATE 10b. COUNT	7			Y, TOWN O							10d. INSIDE CITY
	Maryland Prin	ce Georges		Hy	atts	vil.	le					LIMITS?
Z	10e. STREET AND NUMBER					tof, ZIP CODE				10g. CITI	IZEN OF V	VHAT COUNTRY?
ER	3412 Toledo Terr	race, #B				20782			USA			
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 2 Married 2 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES				13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 NO Specify: 1 Specify:			- American Indian, k, Whita, atc. ity: White				
E I	15. DECEDENT'S EDUCATION (Specify only highest grade completed)			8a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working				166. KIND OF BUSINESS/INDUSTRY				
COMPLETED	Elementary/Secondary (0-12) Collega (1-4 or 5+)			life. Do NOT use retired.)				mt				
MP	12 Yrs		Tax	i Dr	iver Taxi			Taxi				
8	17. FATHER'S NAME (First, Middle, Last)					ts. MOTHER'S NAME (First, Middle, Maiden Surname)						
BE	Morris Silverstein					Yetta (Unknown)						
2						G ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
-	Mark A. Silverstein 19520 Cieneg						enega Avenue, Covina, California 91724					
	1 Burial 2 LXCremation 3 Ramoval from State cametery, crematory or other placal 12/12/1994							1994	ure1		wn, Stata ryland	
	Cmrs						12. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC.					
	Yonald (.	State	Tem	jer					, NW, WAS			
	23. PART i. Enter the diseases, or shock, or heart fallure.	Complications that cause	ned the	eth. Do i	not anter	the mo	da of dylng,	auch	as cardiac or reap	iratory an	reat,	Approximata
	IMMEDIATE CAUSE (Final	A	e section i with			\sim	1 0					Onset and De
	disease pr condition resulting in death)	. 0A	715	10		()	ME	K				YK

OUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated eventa reaulting in death) LAST PART II. Other aignificent conditions contributing to death but not recuiting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 1000

25. WAS CASE REFE	RRED TO MEDICAL		28. PLACE OF DEATH (Check only one)							
1 YES 2 X	NO				OTHER:					
27. MANNER OF DEATH t X Netural 5 Pending 2 Accident Investigation		28s. OATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY AT WORK? M 1 YES 2 NO			28d. DESCRIBE HOW INJURY OCCURED				
3 Suicide 4 Homicide	8 Could not be determined	28a. PLACE OF INJURY — At h building, atc. (Specify)	ome, farm,	atrant, fac	ctory, offica	28I. LOCATION (Street and Number or Rural Route Number, City or Town, State)				

29a. CERTIFIER (Check only one) t CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

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296. SIGNATURE AND TITLE OF PERTIFIER	29c. LICENSE NUMBER 1) 3 2 40 7	29d. DATE SIGNED (Month, Day, Year)

30. NAME AND AD	DRESS OF PERSON	WHO COMPLET		(ITEM 27) (Type, Print)
Joseph	YHA-66	erry	1480£	PHYSICIANS
- 2011		-		10/20/

DEC16 1994 July 2 REGISTRAR'S SIGNATURE 1994

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ROCKVILLE

#212

I YES 2 NO

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3. TIME OF DEATH

B. BIRTNPLACE (State or Foreign

Baltimore, Md

ares

14. RACE — American Indian, Black, White, etc.

white

1 TYES 2 X NO

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24b. WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO

1 TYES 2 NO

COMPLETION OF CAUSE OF DEATH?

Approximats Interval Batween

Onsst and Death

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REG. NO

2. DATE OF DEATN

12 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 1 🗌 M 🕸 🕽 218-54-4053 82 June 11,1912 permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution 9b. CITY, TOWN OR LOCATION OF DEATH Se. COUNTY OF DEATH DIRECTOR 950 ud RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION Maryland Harford BelAir 10e. STREET AND NUMBER FUNERAL 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 950 Redfield Road nours after death. Page 6 may be retained by the hospital or attending physician. d in by the funeral director, page 5 should be detached for use as the burial-transit Apt.F 21014 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yee, specify Cuben, Mexican, Puerto Ricen, atc.)

1 YES 2 NO Specify: BALTIMORE, MARYLAND 21215-0020 1 Never Married 2 Merried ВҮ 3 🕅 Widowed 4 🗌 Divorced ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12th. Homemaker Home once. 17. FATNER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Meiden Surname) Andrew J. Rassa notified at Anna Holdorf 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mr. Joseph J. Sparr 3347 Ady Road Street, Md. 21154 must be 20e, METHOD OF DISPOSITION
1 (A Burlet 2 Cremetion 3 Removal from State 20b. PLACEAND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State DATE Belair Memorial Grds. 12/13/94 BelAir, Maryland 4 Donetion 5 Other (Specify) event, the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE. 22. NAME AND ADDRESS OF FACILITY
E. F. Lassahn Funeral Home 11750 Belair Road the attending physician and completely filled in by the I Mental Hygiene prior to burial, cremation, or removal. Kingsville, Md. complications that caused the death. Do not enter the mode of dying, such es cardisc or reepiratory screet, 23. PART I. Enter the diseases, or shock, or heart fallura. List only one cause on sech line IMMEDIATE CAUSE (Final disease or condition resulting in death) lallycosclerate DIVISION OF VITAL RECORDS, P.O. BOX 68760, DUE TO (OR AS A CONSEQUENCE OF) OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated evants resulting in death) LAST PART II. Other significant conditions contributing to death but not recuiting in the underlying ceuse given in Part i. MEDICAL 24a. WAS AN AUTOPSY signed by the Wodominal anevery shows any 1 TYES 2 NO this certificate has been with the State Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO D PHYSICIAN: UNCERTAIN Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only or EXAMINER? HOSPITAL: OTHER:
4 □ Nursing Nome 5 Residence 6 □ Other (Specify) 1 | Inpatient 2 | ER/Outpatient 3 | DOA 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED Is marked, 1 Natural 1 YES 2 NO ВY After 2 Accident **Investigation** 26e. PLACE OF INJURY - At home, term, street, factory, office 3 Sulcide 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) 6 Could not be determined DIRECTOR: / COMPLETED 28 4 Nomicide Item 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated. TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) H OCME 0 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FER, MD DE L'

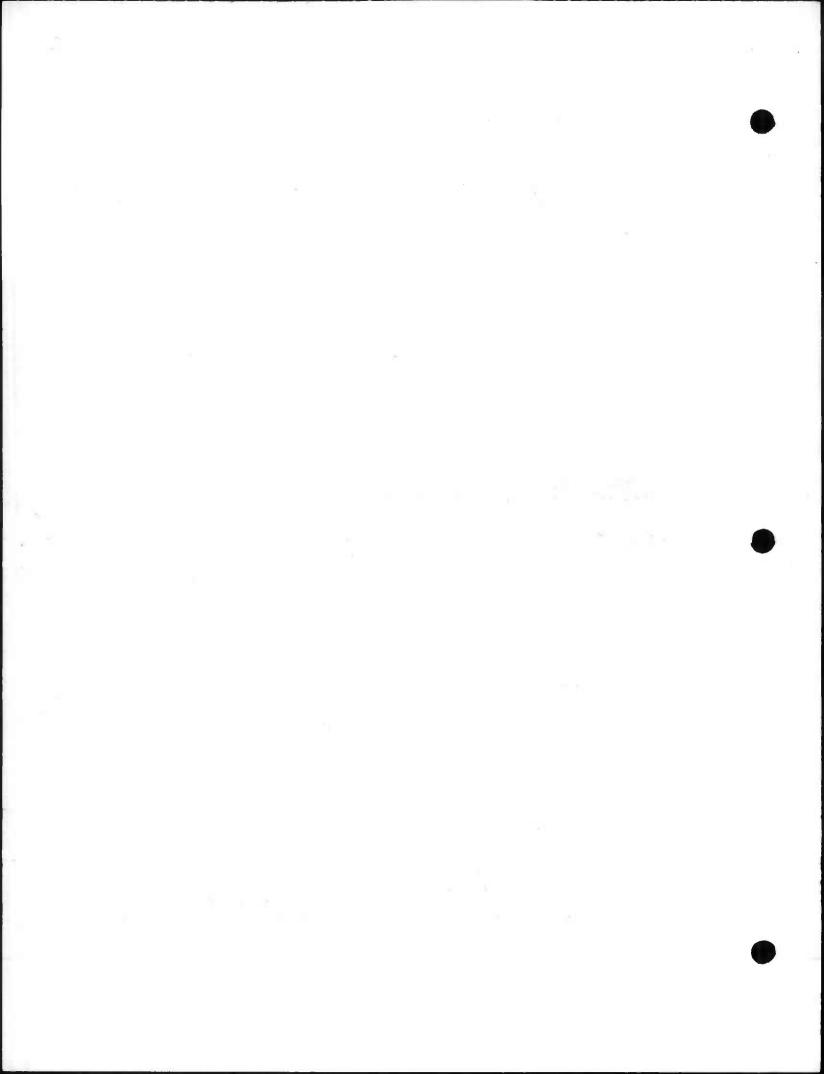
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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DIVISION OF VITAL RECORDS, P.O. BOX 68

DEC16 1994

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		1 - STATE OF I	MARYLAND / DEPA CERTII	RTMENT OF I		ENTAL HYGIEN	E							
		t. DECEDENT'S HAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH						
		Betty J.	SI	PLEY	r	ecember 1	0, 199	4 6:30 p M						
		4. SOCIAL SECURITY NUMBER 5. SEX 1 0 M 2 1 m 2 1 F	6. AGE (In yrs. lest birthday YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) OCT 12, 19	0.	BIRTHPLACE (State or Foreign Country) HILA- PA						
should		9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN	OR LOCATION OF DEA		9c. COUHTY							
1, 2, 3	СТОВ	FRANKLID 58 Hos. BALTO. CO. Baltimore County The STATE THE COUNTY THE STATE THE STATE THE STATE THE COUNTY THE STATE THE S												
t. Pages	DIRE	N J. ATLANTIC	-	AMMON				10d, IHSIDE CITY LIMITS? 1 VES 2 HO						
020 physician. burial-transit permit. Pages	FUNERAL	100. STREET AND HUMBER 525 GRAPE ST. HAM	MONTON.	10	6. ZIP CODE 08037		10g. CITIZEH	OF WHAT COUNTRY?						
215-0020 attending physician se as the burial-trar		1 Never Merried 2 Merried FORCES? 1	T EVER IH U.S. ARMED YES 2 NO	If yes, sp	CENDENT OF HISPAHIC		or No — 14.	RACE — American Indian, Black, White, atc.						
ending as the	ED BY	3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION		'S USUAL OCCUPATION	2 NO Specify:	16b, KIND OF BUS		Specify: WHITE						
21 al or for u	E	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5	(Give kind o	f work done during mo		CRAY	mond	KEARS.						
AND the hospit detached once.	COMPL	17. FATHER'S NAME (First, Middle, Last)	3 5 5 5 5	100	16 MOTHED'S NAME	(First, Middle, Malden	7EY							
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MAR) retained the 5 should notified	TO B	19e. INFORMANT'S HAME (Type/Print)			and Number or Rural Ro									
	ř	BEVERLY PLUNKETT	421	10 MISP	ILLION RE	13 huto 1	NO 21	236						
FOR man e 6 man ector, must		20a. METHOD OF DISPOSITION 1	20b. PLACE AHD DATI cemetery, crematory or	other place) P. Woos	CREMAN	£√ .	CATION - CHY							
ALTIMO death. Page 6 thereal directe		21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. HAME A	ND ADDRESS OF FACI		73	7 BELLEVUE NO						
3AL er deat he fun al.		LASSAHN FUNERAL H	OMERA NESS	LAND	OCLEI FO	NERAL HO	ome A	UE HAMMONTON						
filled in by on, or remo		23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, abock, or heart fellura. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition) At home and leave the cause of												
within mpletel crema		Atherosclerotic Cardiovascular Disease Due to (or as a consequence of): 20 years												
Secu secu secu secu secu secu secu secu s	NO NO	Sequentially list conditions, DUE TO	(OR AS A COHSEQUENCE	OFI:										
a chan	CAT	cause. Entar UNDERLYING		/-										
	CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST	(OR AS A COHSEQUENCE	OF):	<u></u>									
teath certi attending mtal Hygie	E E	d.												
in de p	- T	PART II. Other algnificant conditions contributing to		in the undariyin	g cause given in Pr	ert i. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO						
ECOR puires that signed by Health an	MEDICAL	Congestive Heart Failu				1 YES 2		COMPLETION OF CAUSE OF DEATH?						
REC requires reen sign of Heat		Non Insulin Dependent				_		1 TYES 2 HO						
	AN	DID TOBACCO USE CONTRIBUTE TO CA 25. WAS CASE REFERRED TO MEDICAL		YES NO K	UNCERTAIN									
T t aste	PHYSICIAN:	EXAMIHER? HOSPITAL:	ER/Outpatient 3 DOA	OTHER:										
OF VI PHYSICIAN: this certific with the Si rked, or ii	H	27. MAHHER OF DEATH 28e. DATE OF	IHJURY 28b. TI	ME OF 28c. IHJ	DURY AT	Ed. DESCRIBE HOW II	HJURY OCCUR	D						
	BY	1 Hetural 5 Pending 2 Accident Investigation 2 PLACE C	F INJURY — At home, farm	M 1 🗆	PRK? YES 2 HO	an Location (St.								
TSI TTEN TTEN THER affer	ÉTED	4 Homicide determined	etc. (Specify)	, street, rectory, onic		181. LOCATIOH (Street e City or Town, State)	ind Number or H	urai Houte Number,						
	COMPLE	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of MEDICAL EXAMPLER: On the basis of examples.						use(s) and manner as stated.						
The Hospital The Funeral Filed Within 72 Portant: If	C)	AND SHOMMUNE AND TITLE OF DESTREES		1000	29c. LICENSE NUMB			SNED (Month, Day, Year)						
TO THE be filed	m	//// him) MD		D27315		>	The state of the state of						
, ,	2	30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAU	E OF DEATH (ITEM 27) (Typ.	oe, Print)										
6		M.L. Frydenborg, M.D. /9	000 Frankli	n Square	Drive, B	altimore,	Mary1a	and 21237						

and the second of the second

TO BE COMPLETED BY FUNERAL DIRECTOR

		1, 2, 3 should	
		Pages	
0700-01717 01101111111111111111111111111	IG PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	ils certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
	1 24 hou	y filled intion, or	
1	ed within	this certificate has been signed by the attending physician and completely filled in by the with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	
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	IAN: The	Tificate !	
	PHYSIC	20 7	
	ENDING	R: After er death	
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	THE HI	The ball	Acres described to the
	2	EN	ú

MPDRTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (MOSITI, 6%, 1994

ITEM: 22,	PER I	F.H. FI	LM (G-718 1	2/16/	94 t.t			9	4	37364
FOR STATE		STATE OF M	MARYLA	ND / DEPAR	RTMENT O	F HEALTH AND	MENTAL	HYGIEN	E		
REGISTRAR 1. DECEDENT'S NAME (First	Mirirlio Last)			CERTIF	ICATE C	OF DEATH		REG. NO			
THEODORE	, micro, Eust)	K	SANDERSON				2. DATE O	Dec 9	1994	YEAR	5:40 pm
4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (In	yrs. lest birthday)	AR IF UNDER 24 HRS.	7. DATE O	F BIRTH Day, Year)		6. BIRT	HPLACE (State or Foreign	
215-32-7569		1 X M 2 □ F	91	YRS.	MONTHS DA		DCTOBE	R 23,1	903	NEW Y	YORK CITY, N.Y.
9a. FACILITY NAME (If not in						WN OR LOCATION OF D			9c. CO	UNTY OF	
	Saint Joseph Medical Center Towson, Maryland Baltimore										
10a. STATE	10b. COUNTY			10c. CIT	Y, TOWN OR LO	OCATION					10d. INSIDE CITY
MARYLAND	BALTIMO)RE		WHIT	E MARSH						1 TYES 2 NO
100. STREET AND NUMBER 6029 LORELEY	BEACH F	ROAD				101. ZIP CODE 21162				TIZEN OF	WHAT COUNTRY?
11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN	U.S. ARMED		DECENDENT OF HISPAI			or No-	14. RAC	E American Indian,
1 Never Married 2 1 Divo		FORCES? 1			1 🗍	i, specify Cuban, Mexica YES 2 NO Specif	en, Puerto Ri /y:	can, etc.)		Spec	k, White, etc. ://y: WHTTE
	EDENT'S EDUC			16a. DECEDENT'S	USUAL OCCUP	PATION	16b. I	KIND OF BUS	SINESS/IN	DUSTRY	WILLE
Elementary/Secondary (0		College (1-4 or 5				most of working	0-		. 0) (50		
8	P.440. 4 . 0			PUBLISHER				LF-BMP		_	
17. FATHER'S NAME (First, M ROBERT OSCAR S		J				16. MOTHER'S NA HANNAH AN			Surname)		
19a. INFORMANT'S NAME (7				19b. MAILING	ADDRESS (Str	eet and Number or Rural			n. State. Z	in Code)	-
THEODORE K. SA	NDERSON,	JR.				EACH ROAD WHI					
20a. METHOD OF DISPOSIT	ION	val from State		PLACE AND DATE		(Neme of	DATE	20c. LO	CATION -	- City or To	own, State
4 Donation 5 Other	(Specify)		MET	RO CREMAT	ORY, INC	DECEMBER 12		BAL	TIMOR	E, MA	RYLAND
21. SIGNATURE OF FUNERA	Free		T		LASSA	E AND ADDRESS OF FA	HOME, I		140	04000	
23. PART I. Enter the di		a kom			74U1	BELAIR ROAD	A BALI	IMURE,	MD.	21236	Approximate
snock, or no	eert Isliure. L	lst only one ceu	se on ee	ch line.		mode or dying, suc	on es cardi	oc or respi	ratory s	rest,	Interval Between
IMMEDIATE CAUSE (Fin disease or condition	K	emove									Onset and Death
resulting in desth)	a	STROKE DUE TO	(OR AS A	CONSEQUENCE O	F):						1 YEAR
Sequentially list conditi	lone C b.										
If any, lesding to immediate. Enter UNDERLYI	diete	DUE TO	(OR AS A	CONSEQUENCE O	F):						
CAUSE (Disesse or Inju		DUE TO	(OR AS A C	CONSEQUENCE OF	Pr						
resulting in deeth) LAS	т 📗		(0		. ,.						
DART II Other eignifice	nt conditions		de alle le c			_					
PART II. Other significe	ent conditions	contributing to	deeth bu	t not resulting	in the underl	ying ceuse given in	Pert 1.	PERFOR		246	AWAILABLE PRIOR TO COMPLETION OF CAUSE
							— I	1 TYES 2	NO NO		OF DEATH?
DID TOBACCO U	SE CONTR	IBLITE TO CA	LISE OF	DEATH YE	S 🗆 NO	☐ UNCERTAIN					1 TYES 2 NO
25. WAS CASE REFERRED TO	O MEDICAL			6. PLACE OF DEA							
1 YES 2 NO		HOSPITAL:	ER/Output	tlent 3 DOA	OTHER: 4 Nursing I	Home 5 - Rasidenca	6 Other ((Specify)			
/3	Pending	26a. DATE OF (Month, D	INJURY ny, Year)	26b. TIM INJ	URY	INJURY AT WORK?	28d. DEŞC	RIBE HOW II	NJURY OC	CURED	
3 Suicide 8	Could not be	28a. PLACE O building,	F INJURY -	- At home, farm,				ION (Street a Town, State)	and Numbe	or or Rural i	Route Number,
no continue b	detarmined				_						
						data and place, and due n, death occured at the					i) and manner as stated.
29b. SIGNATURE AND TITLE		IT. d.	0.	n	1.8	29c. LICENSE NUM					(Month, Day, Year)
30. NAME AND ADDRESS OF	PERSON WHO	COMPLETED CAUS	E OF DEAT	TH (ITEM 27) (Type.	Print)	D19508				10/	7/94
NATIVIDAD D						ICAL CENTE	R 7620	YORK	ROA	OT CA	WSON,

A 22 HE TENESSIC TUP

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

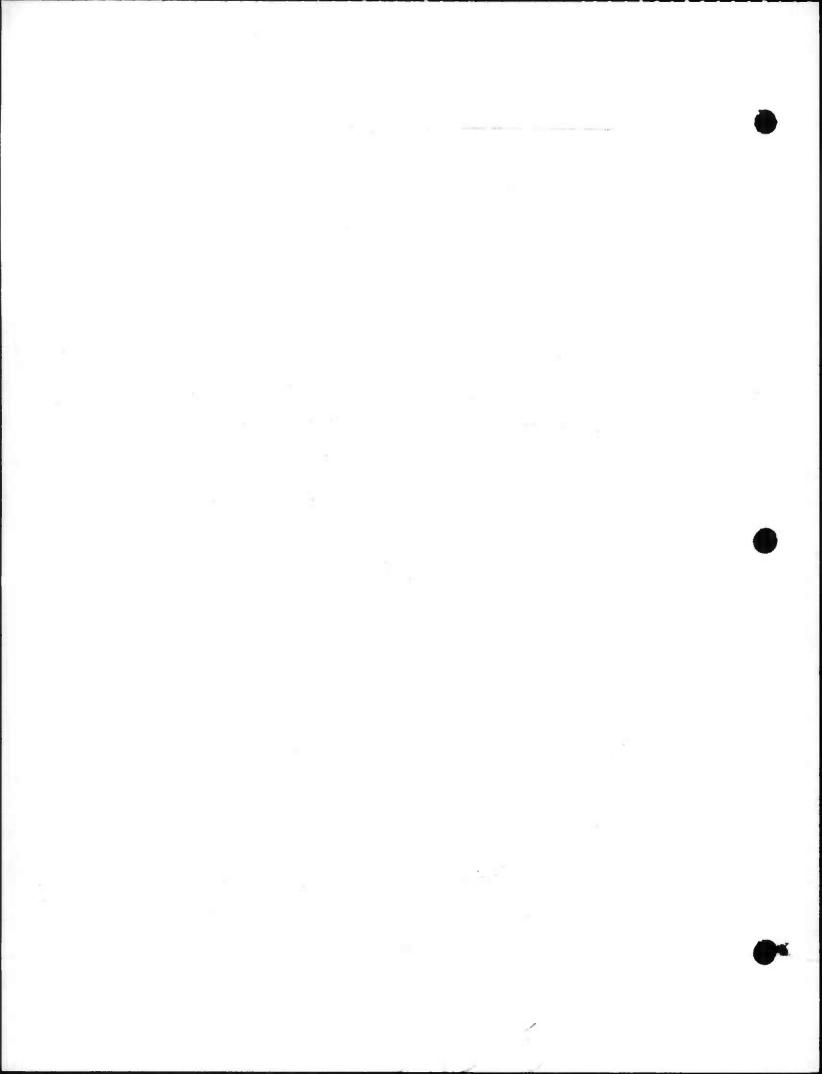
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page 6 may be retained by the hospital or attending physician. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

				94	3736	5
	1 - FOR STATE OF MARYLAND / DEPARTMENT OF H CERTIFICATE OF	EALTH AND ME DEATH	ENTAL HYGIEN	_		
	1. DECEDENT'S NAME (First, Middle, Last)	2	2. DATE OF DEATH		3. TIME OF DEATH	н
	MYRA P. STEWART	1	DEC. 4	YEAR 9.4	2207	рм
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER t YEAR		7. DATE OF BIRTH		NPLACE (State or For	-
		HOURS MIN.	(Month, Day, Year)	Count	ry)	wgn
	70 70 00	^	MAY 21, 19.	59 MAI	RULANI	>
	101 = 0 0 0 0 = 0 = 0 = 0 = 0 = 0 0 0 0	R LOCATION OF DEATH		9c. COUNTY OF D	EATH	
5	401 EAST 25TH STREET APT.#11-E BALTI	MORE CIT	ľΥ	BAITI	MORE	
চ	RESIDENCE OF DECEDENT				·UNL	
DIRECTOR	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATI	ION			10d. INSIDE CITY	
<u> </u>	MARYLAND BALTIMORE BALTI	MORE	0.171		1 YES 2 D	мо
AL	10e. STREET AND NUMBER 10f.	ZIP CODE	7	10g. CITIZEN OF 1	WHAT COUNTRY?	
FUNERAL	3011 MATTHEWS STREET	211	10	USA	1	
Ξ		ENDENT OF NISPANIC	ODICINO (Constitution Visit			-
	1 N Never Married 2 Married FORCES? 1 YES 2 NO It yes, spe	city Cuben, Maxican, P		Blac	E American India: k, Whita, atc.	n,
BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES	2 NO Specify:		Spec	ty: nale	- 1
	15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATIO		T 401 - 1711 - 07 - 070	1 6	-/+CK	
H	(Specify only highest grade completed) (Give kind of work done during mos		186, KIND OF BUS	INESS/INDUSTRY		
Ž	Elementary/Secondary (0-12) College (1-4 or 5+)	11		0-		15.4
COMPLETED	INESTAURANT		SEAF		STAURA	NT
ပ္ပ	17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME	(First, Middle, Maiden	Surname)		
BE	WILLIAM HI STEWART	INE-S	SA	ROGE	25	
10	19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street ar	nd Number or Rural Rout	ite Number, City or Town	n, State, Zip Code)		
Ĕ	IDESSA STEWART BALL MATTHE	EWS ST.	BALTIM	DOF MI	0,212	18
	20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Near	me of		CATION - City or To		
	Burial 2 Cremation 3 Ramoval from Stata Cemetery, crematory or other piece WESTERN STAR (EMETERY	12-14-011 1	ATOM-VII	LE, MD.	, }
1		D ACCRESS OF FACILI	ITY		-	
	JOSE	PH H. B	ROWN JA	?. FUNER	AL HON	1E
	19/30	U. BALTA.	ST, BALT	IMORE 1	10.2125	23
	 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. 	da of dying, auch a	ss cardiac or reapi	ratory arrest,	Approxima	ıta
	iMMEDIATE CAUSE (Final				Interval Be Onset and	
	disease or condition GILLOINT OF ILEAD					1
	resulting In death) a. COND FOOD TO (OR AS A CONSEQUENCE OF):				<u> </u>	-
~					į	- 4
ERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):					
AT	If any, leading to immediate cause. Enter UNDERLYING				į	- 1
윤	CAUSE (Disease or injury that initiated avanta DUE TO (OR AS A CONSEQUENCE OF):				i	
Ē	resulting in death) LAST				i	- 1
CEF	d					\rightarrow
	PART II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Par	rt I. 24a. WAS AN	AUTOPSY 24h	. WERE AUTOPSY FIN	DINGS
S			PERFOR		AVAILABLE PRIOR TO	ro
			_ 1 YES 2	□ NO	OF DEATH?	WSE
Σ			_ / `	1	1 ES 2 N	0
ż	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO	UNCERTAIN			,	_
8	25. WAS CASE REFERRED TO MEDICAL EXAMINER?					
Sic	EXAMINER? TXXES 2 NO HOSPITAL: 1 Inpetlant 2 ER/Outpetlant 3 DOA 4 Nursing Nome	5 ☐ Residence 6¥	Tyother (Specify)	APARTME	ידינאי	
PHYSICIAN: MEDICAL	27. MANNER OF DEATN 28a. OATE OF INJURY 28b. TIME OF 28c. INJU	JRY AT 28	ad. OESCRIBE NOW IN		11/1	\neg
	1 Netural 5 Pending (Month, Day, Year) 220 MM 1 Y		SUB TECT	SHOT		
B	2 Accident	28		nd Number or Rural I	Boute Number	-
	4 Homicide detarmined building, etc. (Specify)		City or Town, State)		WHORE M	0
ᄪ	20. CERTIFIER			1 .)	INDEE TOO	\mathcal{L}
AP.	(Check only 1 CERTIFYING PRYSICIAN: To the best of my knowledge, death occurred at the time, date of the control of the contro					
COMPLETED	2 MEDICAL EXAMINER: On the bents of axamination and/or investigation, in my opinion, de	ath occured at the time	ne, data and placa, and	d due to the cause(s	i) and manner as sta	sted.
C	296. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBE	en I	29d. DATE SIGNED	(Month, Day Year)	-
00	Mark Start I	O.C.M.E		DEC.	5,1994	- 1
임	30. NAME AND ADDRESS OF MERSON WNO COMPLETED PAUSE OF GEATN (ITEM 27) (Typo, Print)	O.C.FI.E	-	DEC.	J, 1774	
	10.101 [0	t Dalt	ma== ::	o 7 7	21201	
l l	MARIO F. GOLW, JR M) 111 Penn Stree	r, parti	пиоте, м	ar A Tallo	L ZIZUI	- 1

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

n certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.	certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dent of Health and Mental Hydiene prior to burial cremation or removal	numstic event the m
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IG PHYSICIA	his certif	you pay
NDING P	O THE FUNERAL DIRECTOR: After this c	MDODTANT: If Item 29 is marked
IL OR ATTENDING	RECTOR	20
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THE HOSPITAL	HE FUNE	TA ATO
10	上の	MDC

	1 - FOR STATE REGISTRAR	OF MARYLAND / D CEF	EPARTMENT OF H		NTAL HYGIENI REG. NO.						
11500	1. DECEDENT'S NAME (First, Middle, Last) Jospeh F. Schae	len JOSEP	H F. SCHA		DATE OF DEATH DAY	1994	3. TIME OF DEATH A				
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 1 AND A COUNTY SEX SEX SEX SEX SEX SEX SEX SEX SEX SEX										
OR	5603 PLymouth Rd	9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 9c. COUNTY OF DEATH									
DIRECTOR	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		Baltin				10d. INSIDE CITY LIMITS?				
	10e. STREET AND NUMBER	,		. ZIP CODE			F WHAT COUNTRY?				
FUNERAL	FOROE	CEDENT EVER IN U.S. ARME S? 1 \(\text{ YES} \(2 \subseteq \text{ NO} \)		2/2/4 ENDENT OF HISPANIC (acity Cuben, Mexicen, P		U.S.A. 14. RACE — American Indian, Black, Whife, etc.					
B	3 Widowed 4 Divorced IF YES,	GIVE WAR OR DATES	1 TYES	3€ NO Specify:		Sį	White				
COMPLETED	15. OECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1	(Give life, Do	DENT'S USUAL OCCUPATION kind of work done during months NOT use retired.)	DN st of working	16b. KIND OF BUS						
SOME	17. FATHER'S NAME (First, Middle, Last)	-	.man	18. MOTHER'S NAME	(First, Middle, Maiden	,	zeα				
H	Philip F. Sch		IAILING ADDRESS (Street of		Gombent						
5	Mr. Philip F. Schae	fen 42	28 Burch	Ave. Ab	ingdon, M	d. 210	209				
	20e. METHOD OF CISPOSITION 1 M Burial 2 Cremetion 3 Removal from St 4 Donation 5 Other (Specify)	20b. PLACE AND Competery, cramal	DATE OF DISPOSITION (Ne tory or other place)	ery	B C	Lto.,1	nd.				
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Smith	22. NAME AI Harta	id Address of Facili ey Mille Hanlond	er Funer	al Hoi	me				
	23. PART V Enter the diseases, or complication shock, or heart failure. Liet only of iMMEDIATE CAUSE (Final disease or condition resulting in death)	ne cause on each line.	n. Do not enter the mo	de of dying, such a	s cardiac or respin	atory arrest,	Approximate Interval Between				
CERTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE DF): c. DUE TO (OR AS A CONSEQUENCE OF): d										
PHYSICIAN: MEDICAL C	PART ii. Other significant conditione contribut	ing to death but not rest	ulting in the underlying	g cause given in Par	PERFOR	i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOP ANIABLE PI COMPLETION OF DEATH?					
N: N	DID TOBACCO USE CONTRIBUTE TO	O CAUSE OF DEATH	YES NO	UNCERTAIN			1 YES 2 NO				
SICIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ND 1 I Input		OF DEATH (Check only one) OTHER: DOA 4 Nursing Hom	• 5 Residence 6	Other (Caratha)						
PHY	27. MANNER OF DEATH 289. D	-	8b. TIME OF 28c. INJ		d. DESCRIBE HOW IN	JURY OCCURED					
ED BY	1 Natural 5 Pending M 1 YES 2 NO										
COMPLET	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the										
BE	2 MEDICAL EXAMINER: On the ba	Can	eatigation, in my opinion, d	29c, LICENSE NUMBE			IED (Month, Day, Year)				
10	30. NAME AND ADDRESS OF PERSON WHO COMPLETE M, KHAN, 5001	ED CAUSE OF DEATH ITEM	aven BI	vd, B	alfins	u - M	121239				
	31. DATE FILED (Month, Day, Year) DEC16 1994	GISTRAR'S SIGNATURE									



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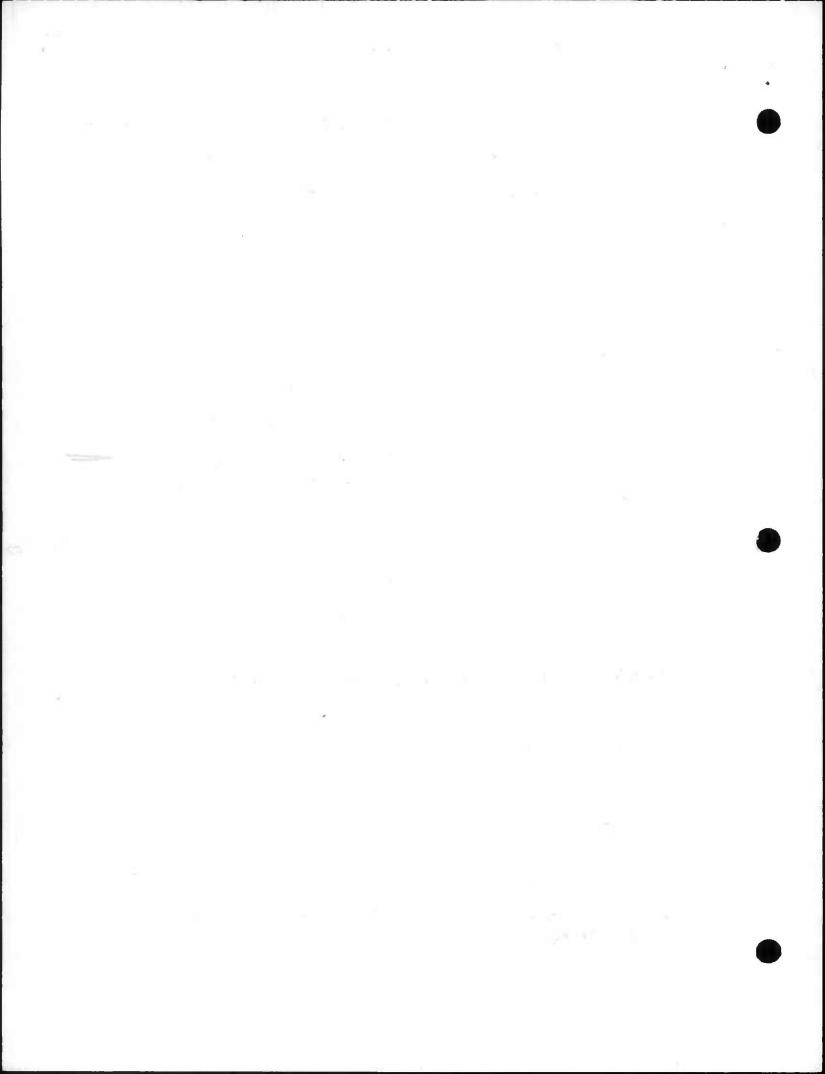
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REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH 1. OECEPENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH PATRICIA SIMPSON SMITH 7:42 LOUISE 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS BIRTHPLACE (State or Foreign MONTHS DAYS HOURS MIN. 1 M 2 W F YRS 219-50-2576 Aug 18, Maryland permit. Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR University Hospital Baltimore 10e. STATE 10b COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g CITIZEN OF WHAT COUNTRY? ter death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the burial-transit I 905 Wildwood Parkway 21229 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 FORCES? 1 YES 2 If yes, specify Cuben, Maxican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Narried 2 X NO Specify: BY 3 Widowed 4 Divorced Black ED 15. DECEOENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade co (Give kind of work done life. Do NOT use retired.) Щ Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 11th Grade Crane Operator Armco Steel Corporation notified at once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Robert Simpson BE Beatrice Dailey 19e. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) 2 Rudy Smith 905 Wildwood Parkway 20e. METHOD OF DISPOSITION
1 X Burlal 2 Cremetton 3 Removat from State
4 Donatton 5 Removat from State Baltimore, May 21229 a 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Deq 7 Donation 5 Other (Specify) King Memorial Park Baltimore County, MD examiner 21. SIGNATURE OF FUNETIAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc hours after death. 2501 Gwynns Falls Parkway Frenn asker Baltimore, Maryland 21216 completely filled in by the ial, cremation, or removal. medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or haert failure. List only one causa on each line. Interval Between **IMMEDIATE CAUSE (Finel** Onset and Death the disease or condition 8 MONTHS resulting in death) executed within event, BOX 68760 burial other traumatic and (CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) 0 if any, leeding to immediate cause. Enter UNDERLYING physician phor CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) P.0. thet initieted eventa attending reaulting in death) LAST 0 Mental in uny, DIVISION OF VITAL RECORDS, PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. she she MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE signed by the DIABETES 23 shows any I 1 YES 2 NO OF DEATH? 1 YES 2 NO been ō DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\overline{\overl PHYSICIAN: has be Dept. OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26, PLACE OF DEATH (Check only one) Item certificate State HOSPITAL: OTHER: 1 TYES 2 NO Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) the 0 28a, DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH this c 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 1 YES 2 NO After th BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, tactory, office building, atc. (Specify) 69 3 Sulcide 26t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED DIRECTOR hours after 28 4 Homicide item 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, dasth occurred at the time, date end piece, and due to the ceuse(s) end menner es stated. TO THE HOSPITAL OF THE FUNERAL D be filed within 72 ho 2 MEDICAL EXAMINER: On the besis of axamination end/or investigation, in my opinion, death occured at the time, data end place, end due to the ceuse(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE 2 COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 22 S. GREENE



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PHYSICIAN: The law requires that the death certificate be executed within wours after death. Page 6 may be retained by the hospital or attending physician.
this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should
with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
for the second second and seco

					31	1 3/360
1 - STATE REGISTRAR			MENT OF HEALTH AND ATE OF DEATH	MENTAL HYGIEN		
1. DECEDENT'S NAME (First, Middle, Last)	C	Stewa	urt	2. DATE OF DEATH MONTH	3 4	3. TIME OF DEATH 2 25A M
4. SOCIAL SECURITY NUMBER 219-44-9596	15 M 2 🗆 F		UNDER 1 YEAR IF UNDER 24 HRS NTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 04-24	48	COUNTRY (AND)
9a. FACILITY NAME (If not institution, give MASON F. LOR RESIDENCE OF DECEDENT			BALT		9c. COUNTY	OF DEATH
10e. STATE 10b. COUNT	TY .		OWH OR LOCATION			10d. INSIDE CITY LIMITS? 1 X YES 2 NO
MASON F. LOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT MARYLAND 10c. STREET AND NUMBER 8 1 3 ARGONNE 11. MARITAL STATUS	DRIVE	<i>D</i> 110	101. ZIP COOE 21218	R	,	OF WHAT COUNTRY?
3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 X YE IF YES, GIVE WAR OR	R IN U.S. ARMED SS 2 NO SOATES 5 / 8 / 70	13. WAS DECENDENT OF HISP If yes, specify Cuban, Maxi 1 YES 2 NO Spe	ANIC ORIGIN? (Specify Yearn, Puerto Rican, atc.)	e or No — 14.	RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 1 2 'T H 17. FATHER'S NAME (First, Middle, Last)	(completed) College (1-4 or 5+)	life. Do NOT use re	done during most of working ATD	16b. KIND OF BU	SINESS/INDUST	
	3 YEARS	ENVIRON	1ENTAL HEALT 16. MOTHER'S UNKN	NAME (First, Middle, Maiden		ARYLAND
19a. INFORMANT'S NAME (Type/Print) MRS. ARNET (A	C. WALKER	4	PRESS (Street and Number or Run HEREFORD RD	al Route Number, City or Tow		
20a. METHOD OF OISPOSITION 1 Burlel 2 Cremation 3 Rea 4 Donation 5 Other (Specify)	moval from State	Ob. PLACE AND DATE OF Cametery, crematory or other	DISPOSITION (Name of) /7	Q / 39#[E 20c. LC	CATION - City	
21. SIGNATURE OF FUNERAL SERVICE L			LEWIS T. GW	YNN FUNER		
23. PART I. Enter the disease, or ehock, or heart failure IMMEDIATE CAUSE (Finel disease or condition resulting in deeth)	Liet only one cause on	each line.	enter the mode of dying, as	uch as cardlec or resp	iratory arrest,	Approximate interval Between Onset and Death
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	С	S A CONSEQUENCE OF):				
PART II. Other algoriticant condition CMV Retruits Depleta 2°	tti W	Salovirus		PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		28. PLACE OF OBATH (- 12"		
PART II. Other algnificant condition CMV Retructs Dipulation 2° DID TOBACCO USE 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Natural 5 Pending	1 Inpetient 2 ER/O	y 28b, TIME 0	Nursing Home 5 Residence F 28c, INJURY AT	a 6 Other (Specify) 28d. OESCRIBE HOW	INJURY OCCUR	EO
2 Accident Investigation	28a. PLACE OF INJU building, atc. (S	RY — At home, ferm, stre	M 1 YES 2 NO	281. LOCATION (Street City or Town, State		tural Route Number,
	us to the cause(s) and ma		use(a) and manner as stated.			
The Control	ER		29c. LICENSE N	UMBER	1	SNED (Month, Day, Year) -/13/94
30. NAME AND ADDRESS OF PERSON W	ISON N	1D 600	n) N wolfe Balt		05	
"DEC16 1994 A	38 REGISTRAR'S	GNATURE				

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the float. Page 6 may be retained by the hospital or attending physician.

TO THE RUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation. or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	Item1 12-16-94 Fil	LmG718 W.	H.Per F	/H							7	L.	31303
	FOR 1 - STATE REGISTRAR	STATE OF N			RTMENT				MENTAL	HYGIENI REG. NO.	Ē		
	1. DECEDENT'S NAME (First, Middle, Last)	1.0								OF DEATH	,	WEAR	3. TIME OF DEATH
	ELLEN Edward	THAWI	EY						NONTI-	- 17	5	94"	800 A"
	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. In:	si birthday)	IF UNDER I		IF UNDER			OF BIRTH , Day, Year)		8. BIRTH	PLACE (State or Foreign
	218-16-8388	1 □ M 2 💢 F	69	YRS.	MONTHS	DAYS	HOURS	MIN.	Feb	4, 192	25		yland
_	9a. FACILITY NAME (If not institution, give s	street and number)			9b. CITY,	TOWN O	R LOCATIO	ON OF DE				INTY OF DE	ATH
6	Stella Maris Hos	pice			Т	ows	on				Ва	ltimo	ore
DIRECTOR	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT	Υ		I too CIT	Y, TOWN OF	R L OCATI	ION						10d, INSIDE CITY
E		ltimore		100.01	Luth								LIMITS?
	10e. STREET AND NUMBER	reimore			Lucii		ZIP CODE				10c CIT	IZEN OF W	1 ☐ YES 2 ☑ NO HAT COUNTRY?
E.	11317 Mays Chape	1 Road					2109				iog. Gr	USA	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDEN	T EVER IN U.S. AF	RMED	13. W	WAS DECE		_	IC OBIGIN	? (Specify Yes	or No.		American Indian,
E	1 Never Married 2 X Married	FORCES? 1	YES 2 X	NO	H	yes, spe	cify Cuba		n, Puerto F	tican, etc.)	0. 110	Black	White, etc.
B	3 Widowed 4 Divorced		AIT OIT BAILS		1.	_ 1E3	2 00 110	арвску.				Specif	White
윤	15. DECEDENT'S EDU (Specify only highes) grade	CATION completed)	18a. DE	ECEDENT'S	USUAL OC	CUPATIO	N at of workin	a	16b.	KIND OF BUS	INESS/IN	DUSTRY	
	Elementary/Secondery (0-12)	College (1-4 or 5 a)		work done do se retired.)	aring mod	a or working	y					
COMPLET	12	$1\frac{1}{2}$	H	lomem	aker					Own H	ome		
	17. FATHER'S NAME (First, Middle, Last)								ME (First, A	fiddle, Maiden S	Surneme)		
BE	William Thomas 190, INFORMANT'S NAME (Type/Print)	Edwards						lrey		Jew			
5	SEE 10 SEC. 11	- 1								er, City or Town			
	Mr. Robert H. Thawley 11317 Mays Chapel Road, Lutherville, MD 2 208. METHOD OF DISPOSITION 208. PLACE AND DATE OF DISPOSITION (Name of DATE 206. LOCATION — City or Town, State												
	1 X Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State	cometery, cre Dento	and DATE	of DISPOSIT	TION (Nar	ne of		017	+			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEZ /	Dento	n Cei			D ADDRES	S OF FAC	Dec	Dei	nton	, Mar	yland
	Duganu	Clan	1							Viedef	eld	Inc.	
	Bryan W. Cla				1	0 W.	. Pac	donia	a Rd.	, Time	oniu	m, MI	21093
	23. PART I. Enter the diseases, or on the shock, or heart feilure.	Complications Use	saused tha da	nath. Do i	not anter t	the mod	de of dyl	ng, such	aa cerd	iec or reapir	atory ar	real,	Approximata Interval Between
	IMMEDIATE CAUSE (Finei	and the state of t											Onset and Daath
	disease or condition reaulting in death)	. ASPIR	ATION	IPN	Emo	NIM	4						10 days
		DUE TO	OR AS A CONSE	OUENCE O	F):								
NO	Sequentially list conditions,	b	(OD 46 4 001/05	01151100 0									
ERTIFICATION	If any, leading to immediate cause. Enter UNDERLYING	002 10	(OR AS A CONSE	OUENCE O	F):								
윤	CAUSE (Disease or Injury that initiated events	c. DUE TO	OR AS A CONSE	OUENCE O	Fi:								
RT	resulting in death) LAST	d.			,								
CE													1
Ä	PART II. Other significant condition					derlying	cause 9	Ivan in F	Part I.	24s. WAS AN / PERFORE		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
DIG	1KHEUMATO,	D PH	THR	1113					_	1 TES 2	XNO		COMPLETION OF CAUSE OF DEATH?
Z									× .				1 YES 2 NO
ä	DID TOBACCO USE	CONTRIBUTE	TO CAU	SE OF	DEAT	H Y	ES 🗌	NO	X				
S	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHER		ACE OF DI	EATH (Che	ck only on	9)			
YS	1 YES 2 NO	1 Inpatient 2		1	4 - Nursi	ing Home		sidence (Hosp		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1								CURED					
ВУ	2 Accident Investigation	88. 54.65.5	P AN ALERWAY		M		ES 2	NO					
	3 Suicide 8 Could not be 4 Homicide determined	zea, PLACE O building,	F INJURY — At ho atc. (Specify)	ome, ferm,	street, facto	ry, offica				ATION (Street as or Town, State)	nd Numbe	or or Rural A	oute Number,
COMPLETED	no centrem > (
MPL	(Check only	CIAN: To the best of											
Ö	2 MEDICAL EXAMINE	H: On the besis of e	amination and/or	inveatigation	on, In my op	oinion, de	ath occur	ed at the t	tima, data	and place, and	due to t	he cause(e)	end manner as stated,
BE (29b. SIGNATURE AND TITLE OF CERTIFIES	C~	6		_		-	NSE NUM			29d, DA1	TE SIGNED	(Month, Day, Year)
5	nondall 2	rall	ever	MA	١		1) c	756	245		P 1	0/19	194
-	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUS	E OF DEATH (ITE	M 27) (Type	, Print)								

ER 2300 DULANEY VALLEY RD.,

32. PROJETRAJES SIGNATURED

Julia distribution Randall

TOWSON, MD

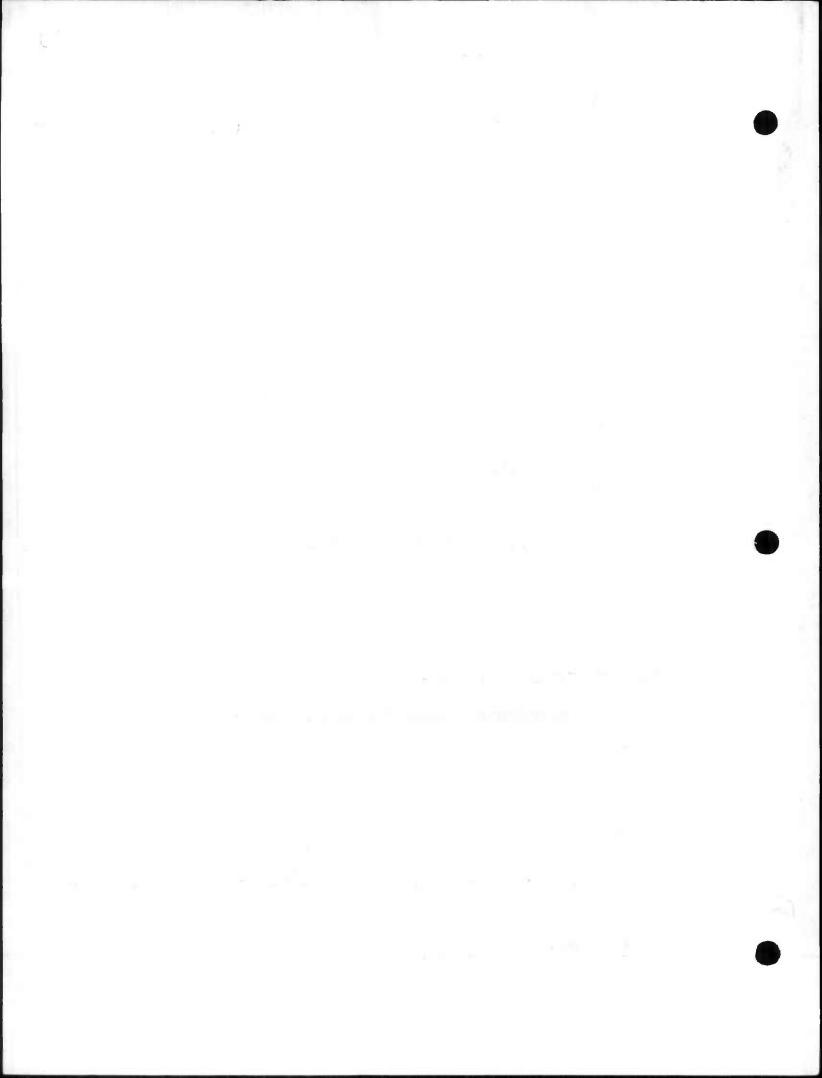
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31. DATE FILED (Month, Day, Year)

DHMH-16 Rev 1/89



BALTIMORE, MARYLAND 21215-0020	4 hours after death. Page 6 may be retained by the hospital or attending physician.	s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	re medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal,	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	HEGISTHAH		CE	LE LE LE LE	CALL	F DEATH	R	EG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last) ROBERT TIMO	тну т	YLER				2. DATE OF I	DAY	YEAR	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	5, SEX	6. AGE (In yrs. last i	hirthday)	IF UNDER t YEA	R IF UNDER 24 HRS.	7. DATE OF E	29	1994	12:52A M HPLACE (State or Foreign		
	223-82-9235	1 🔣 M 2 🗆 F	41	YRS.	MONTHS DAY	HOURS MIN.	March	y, Yeer)	3 Flo	(ny)		
OR	99. FACILITY NAME (If not Institution, give street end number) PRINCE GEORGES HOSPITAL CENTER 9b. CITY, TOWN OR LOCATION OF DEATH PRINCE GEO PRINCE GEO											
DIRECTOR	RESIDENCE OF DECEDENT											
	Virginia Fairfax Annandale											
FUNERAL	100. STREET AND NUMBER 4911 Killebrew Drive 101. ZIP CODE 109. CITIZEN OF WHAT 22003 USA											
BY FUN	11. MARITAL STATUS 12 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT	YES 2 NO		If yes,	ECENDENT OF HISPA specify Cuben, Mexic ES 2 X NO Speci	en, Puerto Ricer		14. RAC Bled Spec	E — Americen Indien, k, White, etc.		
	Whit											
LETE	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.)											
MP	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) 3 Yrs 16b. MIND OF BUSINESS/INDUSTRY (Give kind of work done during most of working life. Do NOT use relired.) Department Of Transportation Federal Government 17. FATHER'S NAME (First, Middle, Last) Robert L. Tyler 18. MOTHER'S NAME (First, Middle, Meiden Surmame) Patricia M. Sides											
ы С												
100	19e. INFORMANT'S NAME (Type/Print)		19b.	MAILING A	ADDRESS (Stre	et and Number of Rural	Route Number, C	City or Town, State	s, Zip Code)			
임	Ronald A. Tyler		69	65 0	ld Bre	ntford Ro	ad, Ale	exandri	a, VA	22310		
	20a. METHOD OF DISPOSITION 1											
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME, INC.											
	23. PART I. Enter tha diagease, or c	May	tterry	ur	232	CARROLL S	T. NW.	WASHIN	GTON.			
	IMMEDIATE CAUSE (Final	e. HUU	ia on aach lina.	211 i						Approximata Interval Between Onset and Death		
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury that initiated avents DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
ERTI	resulting in death) LAST	d										
EDICAL (PERFORMED? AMA									. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
Σ∥	DID TOBACCO USE CONTR	DIRLITE TO CAL	ICE OF DEAT	L VEC		☐ UNCERTAI				1 TYES 2 NO		
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL				(Check only o		иПТ					
SIC	EXAMINER? 1XXE\$ 2 \(\text{NO} \)	HOSPITAL: 1 Inpatient 2	ER/Outpatient 3	DOA	OTHER:	ome 5 - Residence	6 Nother (Sp.	ecify) 140	SPITT			
F	27. MANNER OF DEATH	28e. DATE OF I (Month, Day		28b. TIME INJU	OF 28c.	NJURY AT WORK?	No.	BE HOW INJURY				
BY	1 Natural 5 Pending 2 Accident Investigation	11 - 20	. , ,	1250	ΔM 10	YES 2 NO	15D	STRIP	USTR	ucu Pycha		
8	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify)											
COMPLET	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC ONE) 2 MEDICAL EXAMINED							end menner es	stated.			
	296 OUGNATURE AND TITLE OF CERTIFIER					29c. LICENSE NU						
TO BE	Mayrico Mel	Shell				O.C.				(Month, Day, Year) 29 , 1994		
V	AND ADDRESS OF PERSON WHO					et, Bal	timore	e, Mar	yland	1 21201		
	31. DATE FILED (Month, Cey, Year) DEC 1 6 1994	32. REGISTRAR	S SIGNATURE									

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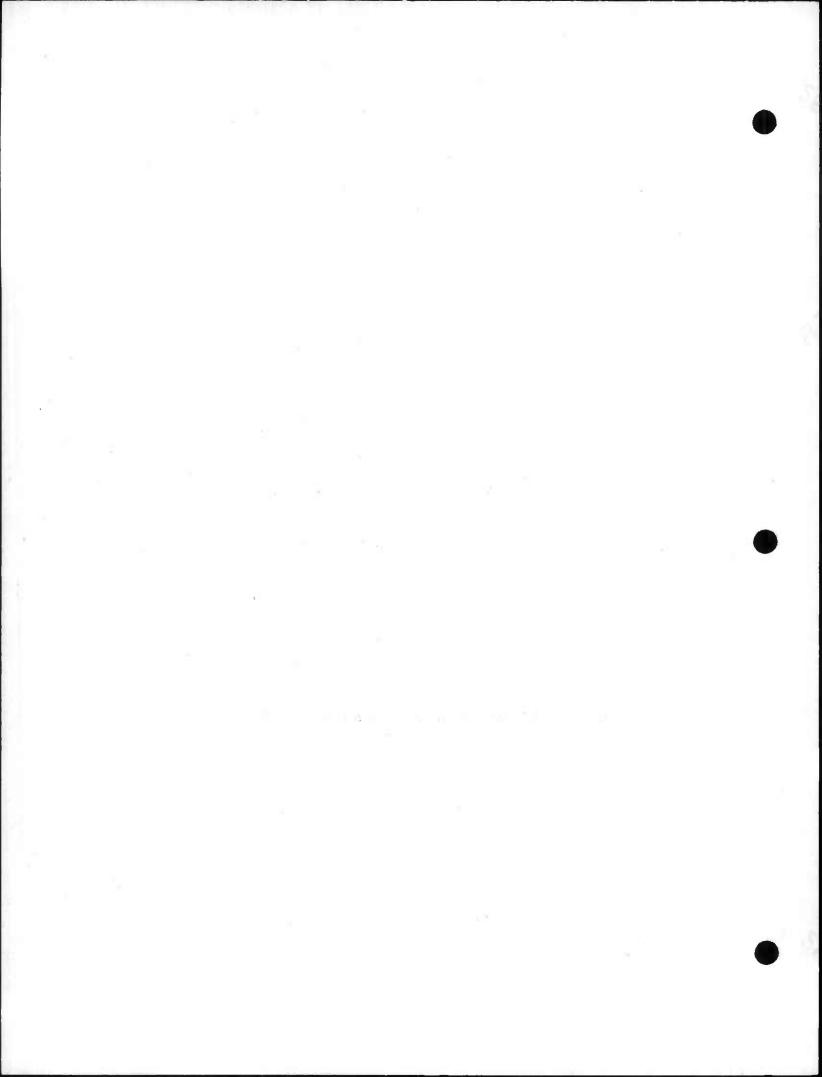
1994

32. REGISTRAR'S SIGNATURE

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN Charles Dec ,1994 Tramue1 С. 3 7:38 P 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTNPLACE (State or Foreign 225-40-1657 62 1 X M 2 F Nov. 19,1932 Virginia as the bunal-transit permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 96. CITY, TOWN DR LOCATION OF DEATH COUNTY OF DEATH DIRECTOR Maryland General Hospital Baltimore N/A 10b. COUNTY 10c, CITY, TOWN DR LOCATION 10d. INSIDE CITY N/A Baltimore Maryland 1X YES 2 NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1722 Division Street 21217 USA nours after death. Page 6 may be retained by the hospital or attending physician 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 1 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: Specify: Black Specify: BY 3 Widowed 4 Divorced ETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY use (Specify only his for Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Maintenance worker should be detached 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Wesley Tramuel Mattie Pendelton notified at BE 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1722 Division Street Baltimore, Maryland 2 Lucy Tisdale page 5 s 20c. LOCATION — City or Town, State pe 20g. METNOD OF DISPOSITION
1 ZABurial 2 Cremation 3 Ren 1177 20b. PLACE AND DATE OF DISPOSITION (Name of must funeral director, Western Star Cemetery atonsville, Md 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNGRAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 5240 Reisterstown Rd Chatman-Harris F/H Baltimore, Md21215 an filled in by the medical 23. PART I. Enter the diseases, or complications that caused the death. Do not aniar the mode of dying, such as cardiac or respiratory arrest, Approximata ahock, or heart failure. List only one cause on each line intervai Between 00 IMMEDIATE CAUSE (Final Onset and Death cremation, traumatic event, the disease or condition Bronchogenic Carcinoma unknown completely resulting in death) executed with DUE TO (OR AS A CONSEQUENCE OF): bunal, CERTIFICATION and Sequantially list conditions, OUE TO (OR AS A CONSEQUENCE OF): THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be ext. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician at filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to I filed. If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? any YES 2 NO OF DEATH? Shows 3 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES | NO | 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) HOSPITAL:
1 Impatient 2 ER/Outpatient 3 DOA OTHER: 1 YES 2 NO 0 27. MANNER OF OEATN 28a. DATE OF INJURY (Month, Day, Year) 28c, INJURY AT WORK? 28b. TIME Of marked, 28d. DESCRIBE NOW INJURY OCCURED 1 Natural
2 Acciden 5 Pending Investigation 1 YES BY 2 NO Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 69 8 Could not be COMPLETED 4 Nomicide 200 item 29a. CERTIFIER 1 XCERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner ea stated. TO THE HOSPITAL
TO THE FUNERAL (
De filed within 72 h
IMPORTANT: If II (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year BE 6 Seece 221. 89213 12-03-94 2 30. NAME AND AODRESS OF PERSON WND COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Muhammad Waseem. M.D c/o Maryland General Hospita

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



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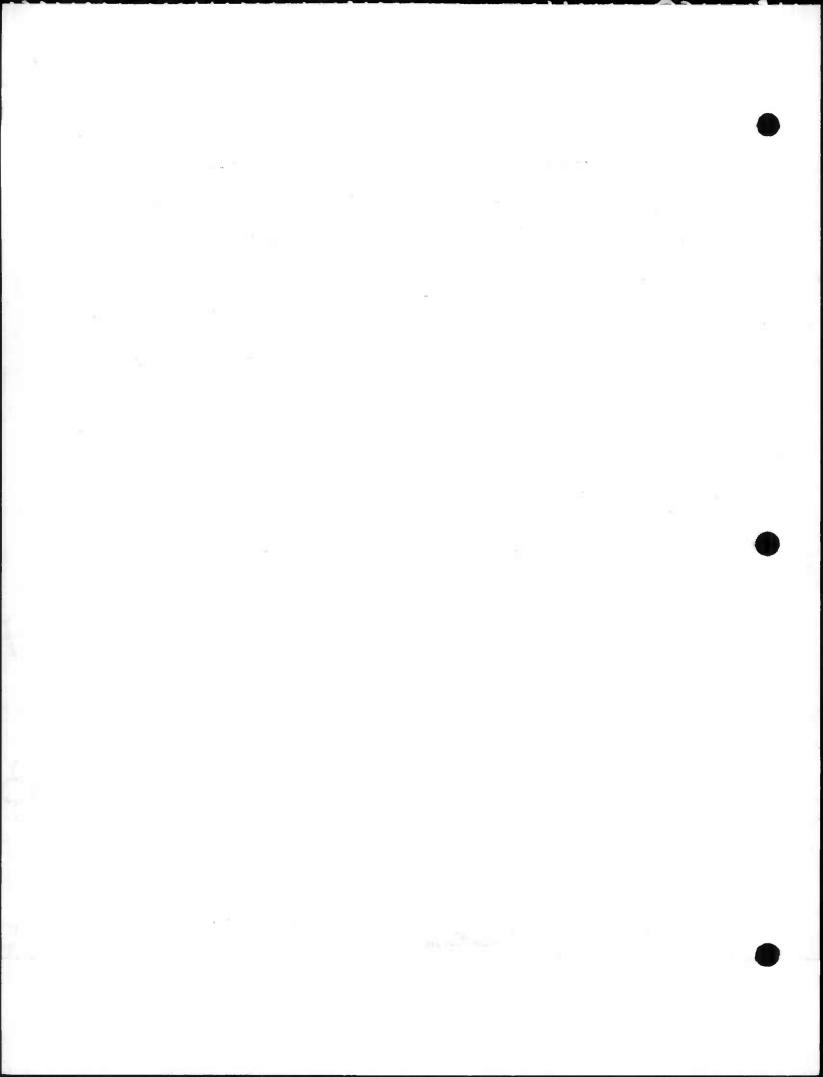
	FOR STATE REGISTRAR	STATE OF MARYLA		ENT OF HEALTH AND	MENTAL HYGIEN	_					
	1. DECEDENT'S NAME (First, Middle, Last)	0 7.1201	r 1 1		2. DATE OF DEATH	MY YE	3. TIME OF DEATH				
	LLNOR	A TURPI		JNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	94					
	THE PROPERTY OF THE PARTY OF TH	215-24-4825 1 M 2 XF 78 YRS. MONTHS DAYS HOURS MIN. SEPT. 2, 1916 MAR									
a	90. FACILITY NAME (If not institution, give LIBERTY MEL	street and number)		CITY, TOWN OR LOCATION OF D	EATH	9c. COUNTY	OF DEATH				
OTO	RESIDENCE OF DECEDENT	TCAL CEN	TER	BALTIMORE	CITY	N	A				
DIRECTOR	10a. STATE 10b. COUNT	Y 41 / A		WN OR LOCATION			10d. INSIDE CITY LIMITS?				
	100. STREET AND NUMBER	NIA	1.	101, ZIP CODE	CITY	1 ✓ YES 2 NO OF WHAT COUNTRY?					
FUNERAL	^	DRUID PARK LAKE DRIVE 21217 USA.									
FUN	11, MARITAL STATUS	ARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13, WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No.) 14. RACE — Ar									
ВУ	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DAT	TES T	1 TYES 2 NO Specif			Specify: BLACK				
ED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working										
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	FOSTER	MOTHER	Fos	TED	CARE				
OMF	17. FATHER'S NAME (First, Middle, Last)		FUSIER		ME (First, Middle, Maider		CINE				
BE C	HERBERT	Yo	RKER	NETT			RIS				
10 B	19e. INFORMANT'S NAME (Type/Print)			RESS (Street and Number or Rural							
	KOSALIND 200. METHOD OF DISPOSITION	WHITE	1223	PARRISH ST							
	1 Burial 2 Cremation 3 Ren 4 Donation & Other (Specify)	rowel from State cemel	PLACE AND DATE OF DIS tery, crematory or other p	(ace)		CATION — City	ORE, MD				
	21, SIGNATURAL OF FUHERAL SERVICE LI			22. NAME AND ADDRESS OF FA	CILITY	e FUN	ERNI HANG				
	1 Kmg	Na-	/	1913 W. BALT							
	23. PART i. Enter the diseases, or ehock, or heart feilure.	complications that caused that only one cause on each	the deeth. Do not e								
	IMMEDIATE CAUSE (Fine)										
	e. DITATEVAL TYCUMONICA DUE TO (OR AS A CONSEQUENCE OF):										
Z	Sequentially list conditions. The Ceve bro Vascular Accident										
ATIC	Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING Service Classes. Chief (Please or Islan)										
E	CAUSE (Diseese or injury that initieted events	OUE TO (OR AS A C	CONSEQUENCE OF):								
CERTIFICATION	resulting in death) LAST	. Meta	bolic	Encephalo	pathy						
AL C	PART II. Other significent condition	na contributing to deeth but	t not recuiting in th	e underlying ceuse given in			24b. WERE AUTOPSY FINDINGS				
					PERFO		AVAILABLE PRIOR TO CDMPLETION OF CAUSE OF GEATH?				
ME					_		1 TES 2 NO				
AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		DEATH YES [ND						
PHYSICIAN: MEDIC	EXAMINER?	HOSPITAL:	ОТ	HER: Nursing Home 5 Residence	6 Other (Specify)						
λHζ.	27. MANNER OF DEATH	28e. DATE OF INJURY (Month, Day, Year)	28b. TIME OF	28c. INJURY AT WORK?	26d. DESCRIBE HOW	INJURY OCCURE	ED				
BY	t Naturel 5 Pending 2 Accident Investigation			M 1 YES 2 NO							
	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — All home, ferm, atreat, factory, office City or Town, State) 28l. LOCATION (Street and Number or Rural Route No. 1) City or Town, State)										
COMPLETED				the time, date end place, and due							
	2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data end place, end due to the ceuse(e) and										
B	Givrey Placeria	ID Hou	Se Alleron	29c. LICENSE NUI			GNED (Month, Day, Year)				
임	30. NAME AND ADDRESS OF PERSON WITH	IO COMPLETED CAUSE OF DEAT									
	31. DATE FILED (Month, Day, Year)	22 REGISTRAR'S STANAT	DO LID	erty Hts B.	altimore	MY	21245				
	DEC1 6 1994 A	why disudion hard	ally								

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. FOR STATE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	C	ERTIFICAT	E OF	DEATH		REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF DEATH	Y_ Y	FAR	3. TIME OF DEATH	
	BERTHA	Ε.	TALLEY					8, 19 ⁸		4:25A M	
		Marie Or District State of the									
	9e. FACILITY NAME (If not institution, give street	and number)	9b. Ci7	TY, TOWN C	OR LOCATION OF DI			9c. COUNTY			
OR	THE JOHNS HOPKIN	NS HOSPITAL		BALTI	MORE CIT	Υ		N	A		
딥	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CITY, TOWN	OR LOCAT	ION					10d, INSIDE CITY	
DIRECTOR	THE VIEW NAME OF THE PARTY OF T	VA		BAL	TIMOR	E			- 1	LIMITS?	
FUNERAL	3579 SHANNON	DRIVE		101	ZIP CODE	.13	10g. CITIZEN OF WHAT COUNTRY?			AT COUNTRY?	
F	11. MARITAL STATUS 12 1 Never Merried 2 Merried	P. WAS DECEDENT EVER IN U.S. AF	RMED 13	I WAS DEC	ENDENT OF HISPAI	NIC ORIGIN	i? (Specify Yae	or No.— 14.	RACE Black,	- American Indian, White, stc.	
B	3 📈 Widowed 4 🗌 Divorced	IF YES, GIVE WAR OR DATES			2 NO Specifi				Specify 121	ACK	
COMPLETED	15. DECEDENT'S EDUCATI (Specify only highest grade com	npleted) (G	ECEDENT'S USUAL	e durina mo	ON st of working	16b	KIND OF BUS	INESS/INDUS	TRY		
12	Elementary/Secondary (0-12) C	College (1-4 or 5+)	A FETER	.)		0 0	ALTER A	0	100	e dilla i a	
OM	17. FATHER'S NAME (First, Middle, Last)		TIEIER	CIPC	18. MOTHER'S NA	ME (First.)	TLIO: CI	TY TUBL	./C	SCHOOLS	
BE C	FRANK	STALLI	NGS		IDA	(, , , , , ,		RIS			
TO B	19a. INFORMANT'S NAME (Type/Print)	19	b. MAILING ADDRE		nd Number or Rural		ber, City or Town	, State, Zip Co			
-	GERALDINE N. T	ALLEY 3	579 SH	ANNO	N DRIVE	BA	LTIMO	RE M	D.	2/2/3 n, State	
	20a, METHOD OF OISPOSITION 1 X Burlet 2 Cremetion 3 Removal 4 Donastin Control Other (Specify)	from State 20b. PLACE cometery, cre	AND DATE OF DISPO	SITION (Na	me of	DAT	E 20c. LO	CATION - City	or Tow	n, State	
	21. SIGNATURE OF CUNERAL/SERVICE LICENS	SEE	22	L NAME AN	IU ADDRESS OF FIL	CHUTY				ILE, MD.	
	1/15/10	with	1	OSEPH 913 W	H H. BROV	√N JR 40RE	ST., H	ERAL HO	OME,	P.A. MD. 21223	
	25. PART I. Enter the diseases, or com	plications that caused the det only one cause on each line	eeth. Do not ente	or the mo-	de of dylng, suc	h as card	flac or respi	ratory arrest	1	Approximats	
	IMMEDIATE CAUSE (Final									interval Between Oneat and Death	
	resulting in death)	e. Attailed fibrillation = rapid ventricular response week									
_											
2	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence or):										
CERTIFICATION	cause, Entar UNDERLYING CAUSE (Disease or Injury	Renal failur	0			_				Gens	
	that initiated eventa resulting in death) LAST	DUE TO (OR AS À CONSE	QUENCE OF):							Just	
GE	d									-	
	PART II. Other significent conditions co	ontributing to death but not i	recuiting in the u	inderiying	ceuse given in	Part i.	24a. WAS AN PERFOR			WERE AUTOPSY FINDINGS	
EDICAL						_	1 YES 2	Guo		COMPLETION OF CAUSE OF DEATH?	
Σ	DID TOPACCO LICE CONTRIB	LITE TO CALICE OF DEA	TH. VEC.	NO 6	1/11/10====1	[1	YES 2 NO	
AN	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		CE OF DEATH (Chec		UNCERTAIN	<u>и</u> П Т					
PHYSICIAN:		OSPITAL: Inpetient 2 ER/Outpetient 3	OTHE	R:	e 5 🗆 Residence	e 🗆 Othe	e (Specific)	···· <u></u>			
并	27. MANNER OF DEATH	28e. DATE OF INJURY	28b. TIME OF	28c. INJ	URY AT			JURY OCCUR	ED		
1 Netural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO											
COMPLETED	3 Suicide 8 Could not be 4 Homicide determined	281. LOCATION (Street end Number or Rural Route Number, City or Town, State)									
٦	29a. CERTIFIER 1 CERTIFYING PHYSICIAN	N: To the best of my knowledge, de	eath occurred at the	time dete	and place, and due	to the seri					
N N		On the basis of examination end/or							ruse(e)	end menner ee stated.	
Б С	29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUN					Month, Day, Year)	
0	Alux E. Shart	o MD			J. H. H. I	-0=	M6123	> /	2/8	194	
2	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH (ITE							.70		
- 1	Stuart E. SI	neiter mo	- Johns	HOP	Kins H	05p	ital				
	31. DATE FILED THOME CONTACTOR	32 REGISTRAR'S GNATURE				1					





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NER	hin .	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be not
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	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5	TO THE FUNERAL DIRECTOR: After this cardificate has been signed by the attending physician and completely filled in by the funeral director, page 5 s be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

94-7	281-0	43	B ITEMS:	23	PAR1	Ι.	II.	27.5	28a-f.	PER	MEO	FILM	G-719	1/5/95	t t	o I.	2	7.0	7	-
olh	ITEM:	23	PART I,	27	PER	MEC	FII	.M G-	718 1	2/30	/94 t	.t		_, _, _		74	J	10) [
OR	a 1 ga. 1 7												MENTAL	HYGIEN	F					

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH	YEAR 3. TIME OF DEATH								
	William CHARLES Vick Dec 14 19	994 0123								
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) YRS. MONTHS DAYS HOURS MIN. MONTHS MIN. MONTHS MIN. MONTHS MIN. MONTHS MONTHS MIN. MONTHS MONTH	B. BIRTHPLACE (State or Foreign Country)								
	A COUNTY NAME OF THE PARTY OF T	TY OF DEATH								
DIRECTOR	Washington County Hospital Hagerstown Washingto									
E	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?								
		1 TYES 2 NO								
FUNERAL	100. STREET AND NUMBER 100. STREET AND NUMBER 101. ZIP CODE 109. CITIZ	EN OF WHAT COUNTRY?								
NS.	1276 Woodbowne the 35 2/239 11. MARITAL STATUS 12. WAS DECEDENT EYER IN U.S. ARMED 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—)	14. RACE — American Indian.								
BY FI		Black, White, etc.								
		Dlack								
H	15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired).	STRY								
12	Elementary/Secondary (0-12) College (1-4 or 5+)									
COMPLETED	17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Melden Surneme)	1								
9 111	Charles W. Vick Dorothy Eargu	hart								
TO BE	196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Jown, Steel, Zip (Code)								
2	20 METHOD OF PROPORTION	md 2/234								
evallines IIInst	20b. METHOD OF DISPOSITION 1 Burlet 2 bt Cremetion 3 Removal trom State 20b. PLACE AND DATE OF DISPOSITION (Name of celebrary or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of celebrary or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of celebrary or other place)	ty or Town, State								
	21. SIGNATURE OF FURERAL BERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY	10, 120								
100	March E. H-West									
	23. PART i. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory stre	at, Approximata								
	ahock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final	intarval Between Onset and Daath								
r, tile	disease or condition resulting in death) SELTURE DISORDER COMBINED DRUG INTOXICATION									
Crean,	DUE TO (OR AS A CONSEQUENCE OF):									
NO NO	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):									
CATION	if any, leading to immediate cause. Entar UNDERLYING									
TIFIC	CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF):									
E E	resulting in death) LAST									
		24b. WERE AUTOPSY FINDINGS								
MEDICAL	SEIZURE DISORDER, DIABETES MELLITUS	AVAILABLE PRIOR TO COMPLETION OF CAUSE								
AED	TIMES 2 I NO	OF DEATH?								
YSICIAN: MET	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\subseteq \text{NO} \subseteq \text{UNCERTAIN } \(\subseteq \)	1 20 10 10								
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? LOSPITAL: 26. PLACE OF DEATH (Check only one)									
	1 YES 2 NO 1 Input lent 2 EXER/Output lent 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28. DATE OF INJURY 28. DATE O									
		RED								
	2 Accident Investigation POUND 12-14-94 1:05 A SUBJECT OVERDOSED									
리쁜ㅣ	4 Homicide determined building, etc. (Specify) PRISON CELL City or Town, SteleyMARYLAN WASHINGTON CO., ME	IN CODD TRICT THINE								
COMPLETED	29e. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.									
BE COMPLE	one) 2 XMEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the									
BEC	296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE	SIGNED (Month, Day, Year)								
TO B	Deruis (Chucte a)	ec 15 1994								
1-1	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
	111 Penn Street, Baltimore, Mar	yland 21201								
1 [31. DATE FILED (Month, Dey, Year) 32. REGISTRAR'S SIGNATURE									

272 EI De E SOX 68760 BALTIMORE, MARYLAND 21215-0020
The presented within 24 hours after death. Pena 6 may be retained by the booked or considered to the considered of

DIVISION OF VITAL RECORDS, P.O. BOX 68760

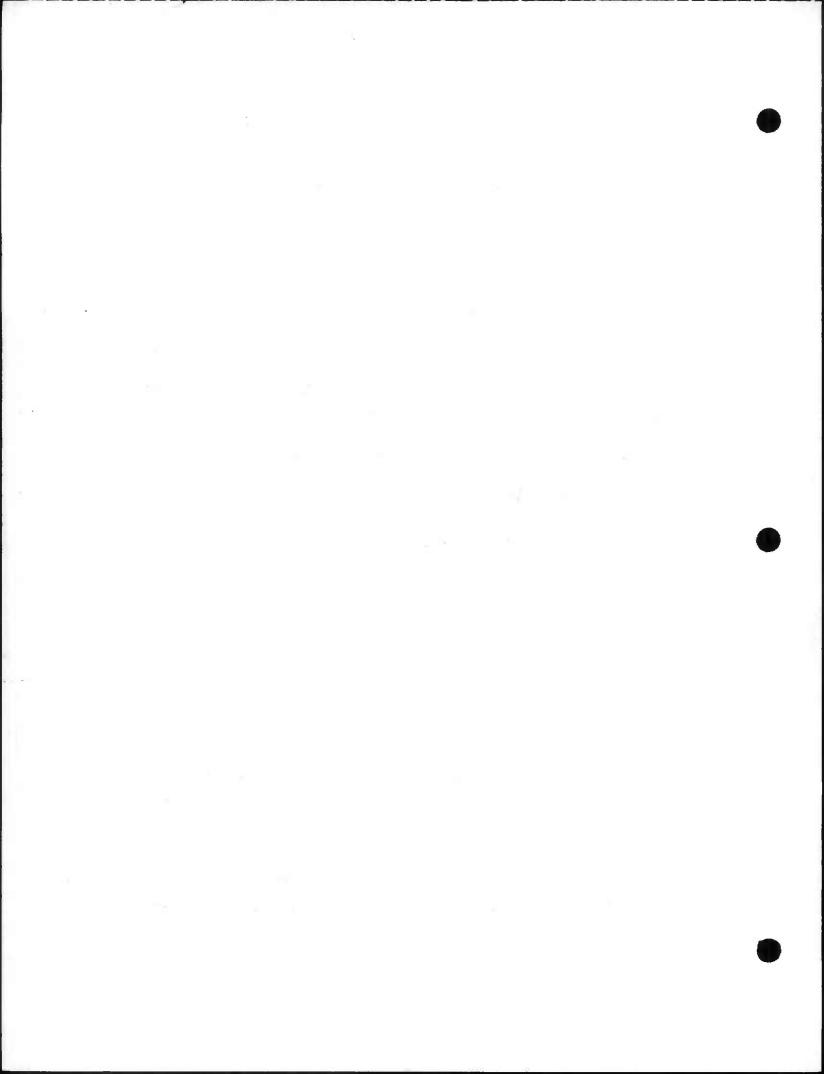
Pages 1, 2, 3 should permit. ned within 24 hours after death. Page 6 may be retained by the hospital or attending physician. completely filled in by the funeral director, page 5 should be detached for use as the burial-transit notified at pe must medicai examiner ŏ the other traumatic event, Hygiene prior to burial, 0 has by Oept. HOSPITAL OR ATTENDING PHYSICIAN: The law 23 OIRECTOR: After this certificate hours after death with the State marked, or 28 Item TO THE FUNERAL O
be filed within 72 h
IMPORTANT: If it THE FUNERAL filed within 72 h

DEC16

TO RESISTRATE SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 1994 AR $P_{\,\scriptscriptstyle{\boldsymbol{M}}}$ WEIGMAN, JR. 13 JOSEPH W. DEC. 10:45 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 1 M 2 F DAYS HOURE 1ar 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORE DIRECTOR SMITH AVE. & LORENA AVE. LANSDOWNE RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland ansdowne 1 TYES 2 X NO FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2400 21 nited)tates 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 € NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American India Black, White, etc. FORCES? 1 Never Merried 2 Merried If yes, specify Cuben, Mexicen, Puerto Rican, etc.) IF YES, GIVE WAR OR DATES 1 TYES 2 NO BY Specify white 3 Wildowed 4 Divorced 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY ET College (1-4 or 5+) Freight COMPL 2 Handler 16. MOTHER'S NAME (First, Middle, Mai Weigman, BE 2 2400 Tionesta Rd., Apt 1D, Lansdowne, MD 21227 Debbie Jeraman 20s, METHOD OF DISPOSITION

1 X Burlal 2 Cremetton 3 Removal from State dowridge Memorial 16 orsey, Maryland LICENSES 22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home, Inc. 328 Sulphur Spring Rd., Arbutus, mo 21227 tagge 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or reepiretory street, shock, or heart fallura. Liet only ona ceuse on each line Interval Betw IMMEDIATE CAUSE (Finel Oneet and Dasth disesse or condition GUNSHOT WOUND OF HEAD resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause, Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted evente resulting in deeth) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? PERFORMED? 1 X YES 2 NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X YES 2 NO OTHER:
4 | Nursing Home 5 | Residence 6 | Other (Specify) | ON STREET 27. MANNER OF DEATH 28e. DATE OF INJURY 28d. DESCRIBE HOW INJURY OCCURED 28c. INJURY AT 1 Natural 12/13/94 10:30P 1 YES ZYNO SUBJECT SHOT В 2 Accident 281. LOCATION (Street and Number of Rural Route Number 2014) Office, SCAN ITH AVENUE LANSDOWNE, MD. 3 Sulcide COMPLETED 6 Could not be 4 THomicide STREET and/or investigation, in my opinion, death occured at the time, date end place, and due to the ceuse(s) and manner as atated. 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) O.C.M.E. DEC.14,1994 2 HO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita Korell M.D. 111 Penn Street, Baltimore, Maryland 21201



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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9	AM DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	-
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ICSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	蜀	the state of the s
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296. SIGNATURE AND TITLE OF CERTIFIER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typa, Print)

OF 07-6 A BEDOW DD

31. DATE FILED (Month, Day, Voar)

DEC16 1994 Julia Dividian Andrea

											5	4	3/3/0
		FOR 1 - STATE REGISTRAR	STATE OF MA					HEALTH F DEA		ENTAL HYGIEN			
	- 3	1. DECEDENT'S NAME (First, Middle, Last)							- T	. DATE OF DEATH	AY		3. TIME OF DEATH
J		Grace Mil	ler White						b			994	1:40 PM
- 1		4. SOCIAL SECURITY NUMBER		AGE (In yrs. las	t birthday)	IF UNDER			R 24 HRS. 7	DATE OF BIRTH (Month, Day, Year)	7		LACE (State or Foreign
		215-09-8747	1 🗆 M 2 📈 F	84	YRS.	MONTHS	DAYS	HOURS	MIN.	6/18/10			timore, MD
		9e. FACILITY NAME (If not institution, give	street and number)			9b. CITY	, TOWN	N OR LOCAT	ION OF DEAT		9c. COUN	NTY OF DEA	
	S S	10910 Reistersto	Owings Mills Baltimo						ore Co.				
	10910 Reisterstown Rd. RESIDENCE OF DECEDENT 100. STATE 100. COUNTY Baltimore Co. Owings Mills Ba Owings Mills Ba Owings Mills											Od. INSIDE CITY	
	E	MD Bal	timore Co.										LIMITS?
	AND AND WARREN												
	ERAI	10910 Reistersto	ıwn Rd.				- [21117			us		
	FUN	11. MARITAL STATUS	12. WAS DECEDENT E			13.	_			ORIGIN? (Specify Yes		14. RACE -	- American Indian,
		1 Never Merried 2 Merried	FORCES? 1 IF YES, GIVE WAR		10			specify Cube ES 2 ∑XNO		Puerto Ricen, etc.)		Black, Specify:	White, etc.
	ВУ	3√√ Widowed 4 □ Divorced						ÆÆ				whi	
	田田	15. DECEDENT'S EDU (Specify only highest grade		(G	CEDENT'S	work done	CCUPAT during i	TION most of worki	ing	16b. KIND OF BU	SINESS/IND	USTRY	
	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)		Do NOT us					modia	- D		
ej S	COMPL									medic			
at on		George Henry N		IAME (First, Middle, Maiden Surneme) Sie Marie Eiser									
notified at once.	BE	190, INFORMANT'S NAME (Type/Print)	mee	191	b. MAILING	ADDRESS	R /Stree	et and Numbe		te Number, City or Tow		Code	
be notif	2	Gordon R. Whit	e. Jr.							d. Owings		-	D 21117
examiner must b		20e. METHOD OF DISPOSITION XIX Burlet 2 □ Cremetion 3 □ Ran 4 □ Donation 5 □ Other (Specify)	noval from State	cemetery, cre	matory, or of	of DISPOS ther place)	omo.	Name of	12/1	DATE 20c. LO 3/94 Pik	O AUI A	Clty or Town	n, State
iner		21. SHOW CTURE OF FUNERAL SERVICE LI	CENSEE	1		22.	NAME	AND ADDRE	SS OF FACIL	ITY 1182	1 Doi	ston	stown Rd.
		Kame B &	line							Home Reis	terst	town,	MD 21136
medical	(23. PART I. Enter the diseases, or shock, or heert fellure.	complications that c	aused the de	ath. Do n	not enter	the n	node ot dy	ing, such s	a cardlec or resp	ratory err	est,	Approximata intervel Between
	Ī	IMMEDIATE CAUSE (Finel	00	1,0									Onset and Death
vent, the		disease or condition resulting in death)	·	11)									
- P			DUE TO (O	R AS A CONSE	OUENCE OF	F):							
traumatic e	RTIFICATION	Sequentielly list conditions,	b. DUE TO (OI	AS A CONSE	DUENCE OF	F):							-
traur t	TA:	if sny, leading to immediate cause. Enter UNDERLYING				,							İ
	띮	CAUSE (Disease or injury that initiated evente	DUE TO (OI	AS A CONSE	DUENCE OF	F):							
or other	ERT	resulting in deeth) LAST	d.										
- 25	O	PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS											
o =	SAL	PART II. Other eigninicent condition	iiii contributing to de	eth but hut r	eeuiting i	in the un	ideriyi	ing cause	given in Pa	rt i. 24a. WAS AN PERFOI		A	VERE AUTOPSY FINDINGS WAILABLE PRIOR TO
5 €	EDIC,									_ 1 🗆 YES 2	-NO		OF DEATH?
									_		1	YES 2 NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DEXAMINER? 1 YES 2 PNO 0 OTHER: 1 Input of 1 Double to 1 Double													
										- P			
e 5	H	27. MANNER OF DEATH	28a. DATE OF IN		28b. TIM	_		NJURY AT		Other (Specify) 8d. DESCRIBE HOW I	NJURY OCC	CURED	
marked,	7	1 Natural 5 Pending	(Month, Day,	Year)	INJ	URY M	A	WORK?					
after death	ED B	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined	28s. PLACE OF II building, etc	JURY — At ho . (Specify)	ma, term, s	street, fect	ory, of	fice	21	81. LOCATION (Street City or Town, State)	end Number	or Aural Rou	ite Number,
Item .		29e. CERTIFIER	ICIANA TO the best of	timents 4.					25011 -			0.0	
は事	MP	(Check only one) 1 CERTIFYING PHYS											and manner as at to d
ANT	8	20h SIGNATURE AND TITLE OF CERTIFIE			vealigatio	, iny 0	-pri-1011,	, seem occu	- o at the fift	, sare and place, er	ove to th	= cause(e) 8	III ITARINIOI 40 SISTOG.

FAIRMOUNT AVE

29c. LICENSE NUMBER
D 1273 2

mit. Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

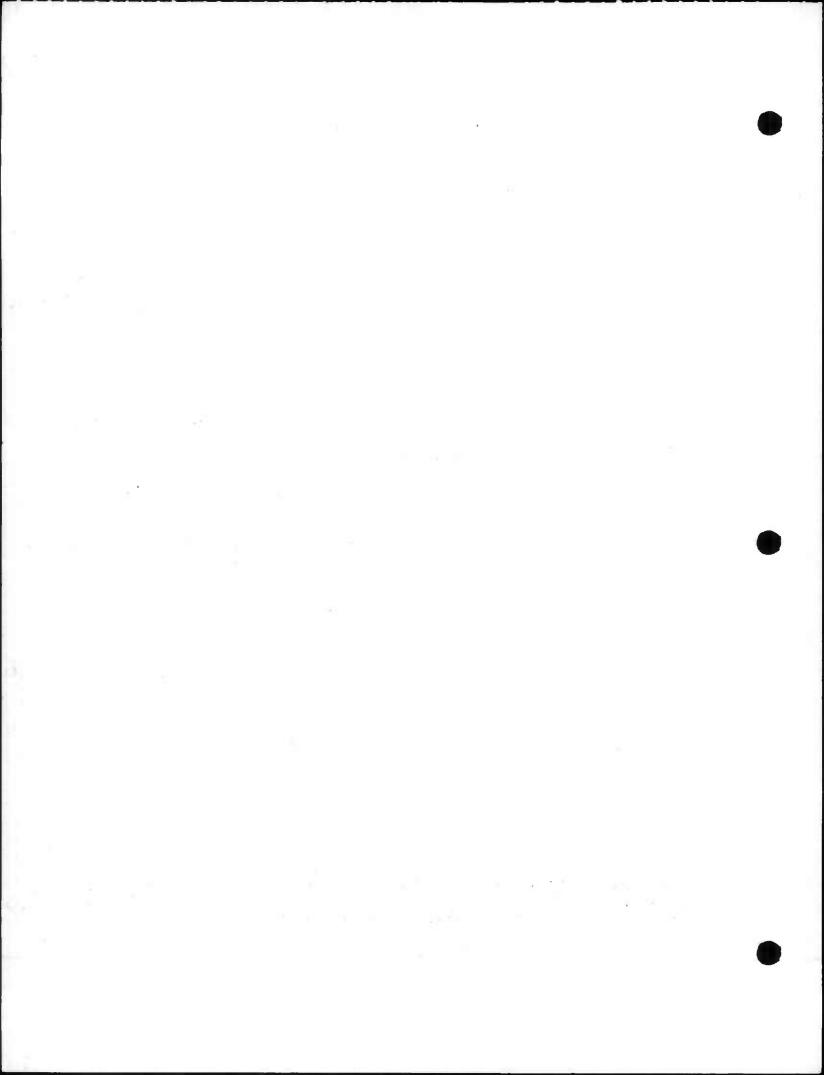
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.	
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FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1 - STATE REGISTRAR	OTALL OF MINISTER	CERTIFIC		DEATH	MENIAL	REG. NO	L			
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE	OF OEATH			3. TIME OF DE	ATN
WILLI	AM EDWAR	D WO	ODSON		Dec	0 1	994	YEAR	11	AM
4. SOCIAL SECURITY NUMBER 5.	. SEX 6. AGE (In	yrs. lest birthday) #	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE	OF BIRTH	227	a. BIRTH	PLACE (State or	Foreign
213-34-3725	№ M ² □ F 57	YRS. MO	NTHS DAYS	HOURS MIN.	Oct.	, Day, Year) 7 1 (937	Mary	yland	
9a. FACILITY NAME (If not institution, give street	(and number)	90		R LOCATION OF DI	-			NTY OF D		
3811 Cedarhurs	t Road		Bal	timore]	N/A		
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c CITY TO	OWN OR LOCATI	ON					10d. INSIDE CI	TV
Maryland N/A	1		timore						LIMITS?	
10e. STREET AND NUMBER	_		10f.	ZIP CODE			10g. CIT	IZEN OF W	WHAT COUNTRY	?
3811 Cedarhurst				21206			L	USZ		
11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	2. Was decedent ever in U Forces? 1 Yes If yes, give war or dat	2 NO		ENDENT OF NISPAI city Cuban, Maxica 2 NO Specif	an, Puerto R		or No—	14. RACE Black Speci	E — American in c, White, atc. fy: Blac	ck
15. OECEDENT'S EDUCAT (Specify only highest grade con	TION 1	(Give kind of work life. Do NOT use re	UAL OCCUPATIO	N It of working	16b.	KIND OF BUS	SINESS/INC	DUSTRY	-	
	College (1-4 or 5+)									
10th grade		Shoe re	epaırm							
17. FATNER'S NAME (First, Middle, Last) Louis E. Woodso	on Sr			18. MOTNER'S NA			Sumame)			
19a. INFORMANT'S NAME (Type/Print)	JII / DI .	19b. MAILING AD	DRESS (Street at	nd Number or Rurel			n Ctoto 7/r	Code)	2120	16
Raymond Woodson				urst R					Maryla	
20g. METNOD OF DISPOSITION 1 ABurlal 2 Cremetion 3 Remova	from State comet	PLACEAND DATE OF D	DISPOSITION (Ner	ne of	2/944	/ 020° LO	cation –	City or To	wn, State	
4 Donation 5 Other (Specify)		ng Memo:			2,10	'Ran	dall	sto	wn, Mo	i
21. SIGNATURE OF FUNERAL SERVICE LICEN	/		1	D ADDRESS OF FA		5240	Rei	ster	stown	Rd
Jerry (1)	orpio		Chatm	an-Hari	ris	F/H E	Balt	imor	e,Md	2121
23. PART I. Enter the diseases, or com ahock, or heart fallure. Lia	plications that caused to only one cause on each	the death. Do not	enter tha mod	la of dying, auc	h ss card	isc or respi	retory an	rest,	Approxi	mate Between
IMMEDIATE CAUSE (Final disease or condition resulting in death)	Squares Oue to (or as a c		Car	insus	1 1	the H	udl	Wet		nd Death
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evants resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. Due TO (OR AS A CONSEQUENCE OF):										
PART II. Other significant conditions of	ontributing to death but	not resulting in t	ha underlylng	cause givan in	Part I.	24s. WAS AN		24b.	WERE AUTOPSY	
						PERFOR			AWAILABLE PRIC COMPLETION OF OF DEATH?	
							•		1 YES 2	NO
DID TOBACCO USE CONTRIB	BUTE TO CAUSE OF	DEATH YES	□ NO □	UNCERTAIL	N 🗆					
	OSPITAL:		THER:	- /						
t YES 2 NO 1	Inpetient 2 ER/Outpet		_	5 Rasidence	_					
1 Netural 5 Pending	(Month, Day, Year)	26b. TIME O	WOF		28d. DES	CRIBE NOW I	NJURY OC	CURED		
2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide datarmined	28a. PLACE OF INJURY – building, etc. (Specify	- At home, farm, stree	et, factory, office		28f. LOCA City o	ATION (Street a or Town, State)	and Number	or Rumi R	loute Number,	
29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: C	N: To the best of my knowled On the besis of examination a) and manner as	stated.
29b. SIGNATURE AND TITLE OF CERTIFIER Maryly Charles	may 1	1.0.		29c. LICENSE NUI	MBER -46		29d. DAT	E SIGNED	(Month, Day, Yea 94	ir)
30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEAT		1. OF A	D. Hos	P.	22 S	GRE	ENE	BACTO	M
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

Pages 1, 2, 3 should permit. Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-transit funeral director, nding physician and completely filled in by the Hygiene prior to burial, cremation, or removal. DIRECTOR: After this certificate has been signed by the attending physician hours after death with the State Dept. of Health and Mental Hygiene prior to OR ATTENDING PHYSICIAN: The law THE FUNERAL I THE HOSPITAL TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 8

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF OEATH WARD 1994 EVELYN DECEMBER 10 10:50 a. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 093-12-5973 HOURS 1 M 2 X F SEPT. 27 YRS VIRG INIA 9a. FACILITY NAME (if not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORE CITY DIRECTOR THE JOHNS HOPKINS HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND 100. STREET AND NUMBER BALTIMORE t X YES 2 NO FUNERAL 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2235W. BALT 21223 MORE 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE - American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed + Divorced B ETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) 8tH GRADE COMPL INKNOWN PERSON notified at once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname OLIVER HOWARD MAGGIE GRAVES BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 RIDDICK WILLIAM BALTIMORE BALTO MD, 20a, METHOD OF DISPOSITION

1 Burlel 2 Cremetton 3 Removal from State
4 Donation In Other Counts be 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Donation Jo Other (Specify) EMETERV 12-14-94 BALTIMORE, MD medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD.21223 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory strest, shock, or heert feilure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Finel Onset end Death the disease or condition Adult Respiratory Distress Syndrome other traumatic event. resulting in death) DUE TO (OR AS A CONSCOUENCE OF): (rastro-Intestinal 13100d 1095 month CERTIFICATION Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING Hyper truptic Co Cording opath years CAUSE (Disease or injury thet initiated events resulting in deeth) LAST Renel Stage 20 years Discare injury, PART II. Other significent conditions contributing to deeth but not recuiting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL any Hypertension 1 YES 2 NO OF DEATH? Shows 1 | YES 2 (50) DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO MOUNCERTAIN I PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) Item HOSPITAL OTHER: 1 YES 2 NO inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 0 28c. INJURY AT WORK? 27, MANNER OF DEATH 28a, DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 26d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural
2 Accident Pending 1 YES 2 NO BY Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 80 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 28 4 Homicide Неш 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(s) and manner as stated. Ξ 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29h. SIGNATURE AND TITLE, OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Arwanet 94 M620 0 MUD 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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32 RECUSTION'S SIGNATURALLA

Hopkins

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J.S. Janamote

1994

31. DATE FILED (Month, Day, Year)
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BALTIMORE, MARYLAND 21215-0020 tter death. Page 6 may be retained by the hospital or attending physician. The funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should

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VISION	ATTENDING PHYSICAL
DIVISION OF WIT	AL DR ATTENDING PHINGRAM

TO THE MOSPITAL OR ATTENDING THE ACCUSAGE IN TREQUES that the death certificate be executed within 25 hours after death. Page 6 may be retained by the hospital or attending	TO THE FUNERAL DIRECTOR: After the contraction been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the	be filed within 72 hours after dea 👚 🐃 Lept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If item 28 is marked within 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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						94	37379	
	1 - STATE OF MARYLAN	ID / DEPART CERTIFI	MENT OF I	HEALTH AND	MENTAL HYGIEN REG. NO	_		
	1. DECEDENT'S NAME (Figur, Middle, Last) ACQUELLUE L	Mi	0-				3. TIME OF DEATH	
DIRECTOR		yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		4 0330 FM BIRTHPLACE (State or Foreign	
	217-62-4422 1 D M 2 X F		MONTHS DAYS	HOURS MIN.	9/4/1953		Balto., MD	
	9a. FACILITY NAME (If not Institution, give street and number)			OR LOCATION OF D	EATN	9c. COUNTY		
	Liberty Medical Center		Ba	1timore	e			
	10a. STATE 10b. COUNTY	10c. CITY,	TOWN OR LOCA				10d. INSIDE CITY LIMITS?	
	Maryland 10e. STREET AND NUMBER		Balti	MOTE			1 X YES 2 NO	
FUNERAL	1525 N. Ellamont Street		10	212	16	10g. CITIZEN	USA	
N D	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U	S. ARMED	ARMED 13 WAS DECEMBENT OF		OF HISPANIC ORIGIN? (Specify Year			
ВУ	1 X Never Merried 2 Married FORCES? 1 YES 3 Wildowed 4 Divorced FORCES? 1 YES	z Z	If yea, specify Cuban, Maxica 1 YES 2 NO Specify				Specify:	
	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	60. DECEDENT'S U	ISUAL OCCUPATION	ON	16b. KIND OF BUS	SINESS/INDUS	Black	
	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT use	ork done during mo retired.)	ost of working				
COMPLETED	12th 17. FATHER'S NAME (First, Middle, Last)	·	n/a	1		n/a		
uı l	Sylvester White		16. MOTHER'S NAME (First, Middle, Malden St. Dorothy			Surname)		
10 BI	19a. INFORMANT'S NAME (Type/Print)			and Number or Aural	Route Number, City or Tow			
F	Dorothy White				St. Balti			
	20a. METNOD OF DISPOSITION 1 □ Burlel 2 Scremetion 3 □ Removal from State 4 □ Donation /5 □ Other (Specify)	tro Cr	DISPOSITION (No er place)				or Town, Stata	
	21. SIGNATURI OF TUNERAL SERVICE LICENSEE	CIO CI	22. NAME A	ND ADDRESS OF FA	ACILITY		ille, MD	
	23 PART 5 the disease of constanting that	ltt	4600	LIBERT	TY HEIGHT	S AVE	ERAL HOME NUE 21207	
	23. PART Length the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, approximate interval Between Onset and Death Onset and Death							
	disease or condition resulting in deeth) a. Selass							
	DUE TO (OR AS A CONSEQUENCE OF):							
NO	Sequentially list conditions, Due to (or as a consequence of):							
Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): AULUM DUE TO (OR AS A CONSEQUENCE OF):								
TIFI	that initiated eventa resulting in death) LAST	ONSEQUENCE OF)		Leuli	110			
CER	d. Acces	nun	6					
SAL	PART II. Other significent conditions contributing to death but	not resulting in	the underlyin	g cauea given in	Part I. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
MEDICA					1 TYES 2	□ NO	OF DEATH?	
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES TO NO						1 TYES 2 NO	
CIA	25. WAS CASE REFERRED TO MEDICAL FYAMINED? 26. PLACE OF DEATH (Check only one)							
PHYSICIAN:	1 YES 2 NO 1 Inpatiant 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Realdence 6 Other (Specify)							
	27. MANNER OF DEATH 1 Netural 5 Pending 28a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF 100 100 100 100 100 100 100 100 100 10			SCRIBE NOW INJURY OCCURED		
Э ВУ	Accident investigation Accident Investigation 28e. PLACE OF INJURY	At home, ferm, str					per or Rural Route Number,	
IEI.	4 Nomicide determined building, etc. (Specify)				City or Town, State)	S. 1806C. 31	and the second second	
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledgene							
CO	MEDICAL EXAMINER: On the basis of exemination of	nd/or Investigation	, in my opinion, d	feath occured at the	time, data and place, en			
BE	296, SIGNATURE AND TITLE OF CERTIFIER HO	use M	Marin	29c. LICENSE NU	MBER 5/Q7	29d. DATE SI	GNED (Month, Day, Year)	
2	30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	W-E / 10	Januar	1 24	1001	10	X-10-17	

96. SIGNATURE AND TITLE OF CERTIFIER 18 90 WWW 1 MW	House Mysicia	- 11/1/20	29d. DATE SIGNED (Month, Day, Year) 12-10-94
O. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSI BIKICHM S. JOMAI	E OF DEATH (ITEM 27) (Type, (First)	D Would HISA	v Balto.

31. DATE FILED (Month, Day, Man) 32. REGISTRAN'S SIGNATURE /2 / 10 1 5 16 1994 July of Audion Revolution

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O	THE RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020 THE RECORDS AND THE LAW requires that the death certificate be executed within a four data. Page 6 may be retained by the hospital or attending physician. THE REPORT AND T	TO THE FLORE AT INSTANCE AND THE THE THE THE THE THE THE THE THE THE	be find than 72 our man doub with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTMENT and man 28 is marked, or liem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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MEDICAL

PHYSICIAN:

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

REGISTRAR'S SIGN

ACIAN MA

MACHEDY

31. DATE FILED (Magin, Day, Year)
DEC1 6 1994

1994

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Estella Mary Zinkhan 4:05 AM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH
(Month, Day Year)
Aug. 21, 1914 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 218-18-0021 1 M 2 X F 80 Balto. Md. YRS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH Carroll County General Hospital Westminster Carroll RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Carrol1 Westminster 1 TYES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101. ZIP CODE 201 St Mark Way Apt. 112 21157 **IISA** 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married If yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES Z NO Specify: White 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION (Specify only highest grade comple 18a. DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) 12 Housewife 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle Maiden Surname) Clarence Belschner Elsie Newton 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Karl E. Zinkhan 201 St. Mark Way Westminster, Md. 21157 20s. METHOD OF DISPOSITION
1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, State etery, cremetory or other place)
Druid Ridge Cemetery 12/19/94 Pikesville, Md. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADORESS OF FACILITY 11824 Reisterstown Road Camst time Eline Funeral Home Reisterstown, Md. 21136 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition___ Questout resulting in death) Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AMAIL ARLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 1 M 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 - YES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OEȘCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide determined 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(a) end manner ee stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 296. SJONATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) whellphink Naparre

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EPITAL OR ATTENDING PHYSICIAN: The law

permit. burial-transit ours after death. Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for use as the notified at pe must medical examiner and completely filled in by the oburial, cremation, or removal. the event, other traumatic prior to the attending physician Mental Hygiene prior to 10 injury, signed by t Health and any shows : : After this certificate has been death with the State Dept. of h 23 6 marked, 69 DIRECTOR: / item 28 A Z

Pages 1, 2, 3 should

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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign (Month, Day, Year) 11/20/1959 DAYS HOURS MIN. 1 M 2 🗌 F Georgia 219-76-4510 YRS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Johns Hopkins Bavview Medical Ctr. Baltimore City RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Baltimore Dundalk Maryland 1 TYES 2X NO 10a STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21222 6817 Roberts Avenue United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 25 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO If yes, specify Cuban, Mexican, Puarto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 1 Married White 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compl (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5 +) 2 Years Baltimore City Police Government 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumame) Frank Luke Astarita, Sr. Beverly Ann Mitzel 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6817 Roberts Avenue Dundalk, Maryland 21222 Mrs. Patricia L. Astarita 20a METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Sacred Ht. of Mary Cem.12/19/94 Baltimore, MD 4 Donation 5 Qther (Specify) 21. SIGNATURE OF FONERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DOCK PUNCTAL HOME of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23. PART I. Enter the diseases, o) complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate interval Batween IMMEDIATE CAUSE (Final **Onset and Death** disease or condition BEPSIS days resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditions, CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST PART ii. Other algorificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY 1 TYES 2 NO OF DEATH? 1 TES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO VE UNCERTAIN 26. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL OTHER: 1 YES 2 NO patient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 - Rasidence 6 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 26d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO Accident 281. LOCATION (Street and Number or Rural Route Number, City or Yown, State) 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 6 Could not be 4 Homicide determined 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner ea stated MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIE 29d. DATE SIGNED (Month 29c. LICENSE NUMBER

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WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

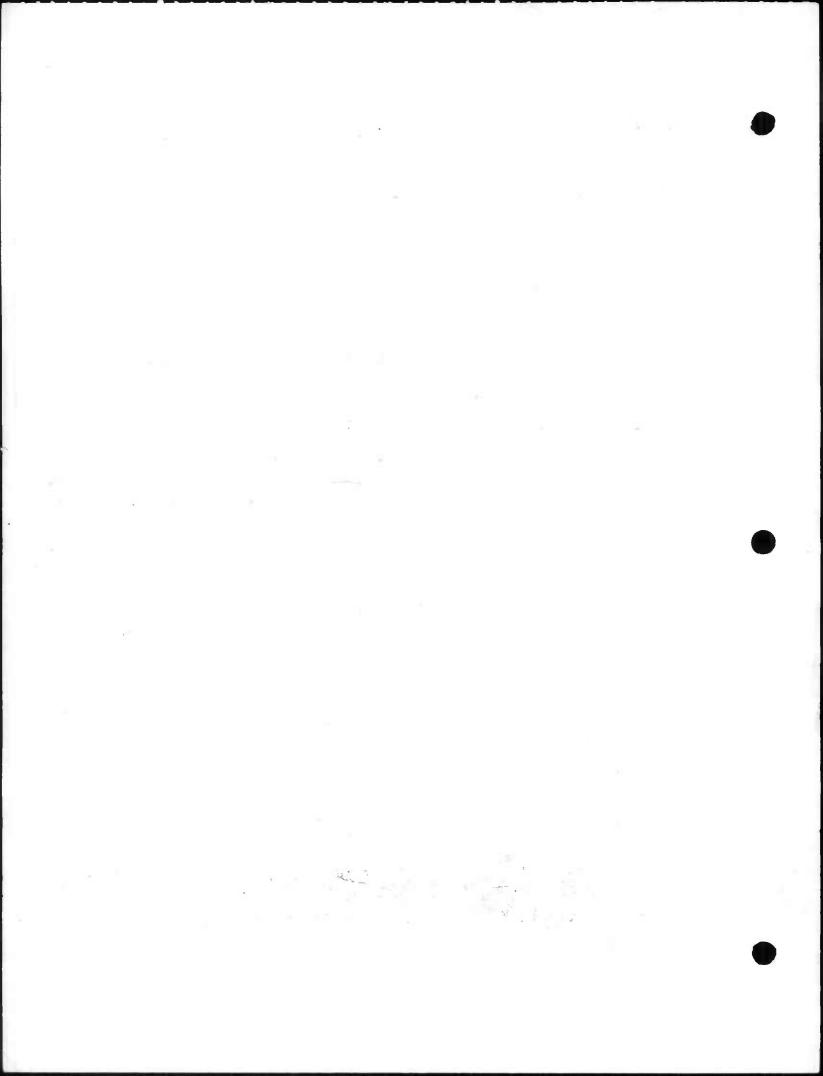
32. REGISTRAR'S SIGNATURE

M.D.

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Julia

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BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. be filed within 22 for the first death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT If item 28 is pracked, or frem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPIAL OF ATTENDARD PHYSICIAN: The law requires that the death certificate be secured within TO THE FUNDAL DESCRIPTION and the complete of field within 72 regulations and with the State Deer, of Health and Mental Horsieva notes in hurtan examents.

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIFIC	ATE OF DEAT	Н	REG. NO.				
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE C			3. TIME OF DEATH		
	Collin		Anthon	V	MONTH De	DAY 16	YEAR	0216 M		
	Adda de de de	5. SEX 6. AGE (In	yrs. last birthday) II	UNDER 1 YEAR OF UNDER 2	MIN. 7. DATE O	F BIRTH Day, Year)		HPLACE (State or Foreign		
	9a. FACILITY NAME (If not institution, give street	~	01	b. CITY, TOWN OR LOCATION		01-37	UNTY OF E	ZIT CHAOLINA		
TOR	1100 N Carroll	UNIYOF	PEATH							
DIRECTOR	10a. STATE 10b. COUNTY		10d. INSIDE CITY LIMITS? 1 X YES 2 NO							
- 1	MANYLAND 104. STREET AND NUMBER 106. STREET AND NUMBER 109. CITIZEN O							WHAT COUNTRY?		
FUNERAL	1100 N. CARROL			21:	217		4.5	5. A.		
B	1 MARITAL STATUS 1 Mever Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 NO	13. WAS DECENDENT OF It yes, specify Cuban, 1 YES 2 NO	Maxican, Puarto Ri	Blac	14. RACE — American Indian, Black, Whita, atc. Specify: BLACK			
E I	15. DECEDENT'S EDUCAT (Specify only highest grade co		18a. DECEDENT'S US (Give kind of work	UAL OCCUPATION done during most of working stired.)	16b. I	(IND OF BUSINESS/II	DUSTRY	00.00		
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	CAX (U)	ASHEL		SERVIC	28			
	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname)									
BE	NICK HNTHONY 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Boute Number, City or Town, State, Zip Code) 122.73									
5	JOHNW ANTHON	'X/		V. MULBER		BALTIMON	E. L	ARYLAND		
	20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ramovi 4 Donation 5 Other (Specify)		PLACE AND DATE OF D tery, crematory or other	place)	DATE 12/2	20c. LOCATION -	- City or To	MARULAUX		
	21. SIGNATURE OF THEMPHAL SERVICE LICEN	ISEE /	00	22. NAME AND ADDRESS	OF FACILITY BRE	OWN CON	144	VITY FIA		
_	Tearles 400	But		1200 W	. NORT	4 AUE.				
	23 PART I. Entar the diaeases, or cor shock, or heart failure. Lis IMMEDIATE CAUSE (Final disease or condition	at only one ceuse on each	the death. Do not ch line.	2 -	g, such as cardi		rreat,	Approximate Interval Between Onset and Deeth		
	reaulting in death) a.,	DUE TO (OR AS A	CONSEQUENCE OF):	a service as a	1 Jus					
VIION	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING									
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d. d.									
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS									
DICAL	244. WAS AN AUTOPSY PERFORMED? VES 2 \(\triangle \tria									
ME	DID TORACCO LISE CONTRIBUTE TO CALISE OF DEATH VES TI AND THE LINICEPTAIN TO									
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Chack capt) (200)									
딣	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1									
BY PHYSICIAN:	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME O	F 28c. INJURY AT		RIBE HOW INJURY O	CCURED			
ĕ.	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJUR	WORK? M 1 YES 2	NO					
COMPLETED B	3 Suicide 8 Could not be determined	28s. PLACE OF INJURY - building, etc. (Specif	28a. PLACE OF INJURY — At home, tarm, street, factory, offica building, etc. (Specify)			281. LOCATION (Street and Number or Rural Route Number, City or Town, Stete)				
	29a. CERTIFIER 1 CERTIFYING PHYSICIA	AN: To the best of my knowle	dge, death occurred s	t the time, data and place, a	and due to the cause	e(a) and manner as at	sted.			
WO	anal .	On the basis of examination						a) and mariner as stated,		
BE C	296. SIGNATURE AND TITLE OF CERTIFIER	11		29c. LICEN	SE NUMBER .	29d. DA	TE SIGNED	(Month, Day, Year)		
	They dry M. King mil. Dec 16 1994									
임	30. NAME AND ADDRESS OF PERSON WHO C	COMPLETED CAUSE OF DEAT		nt)						
	21. DATE FILED (MOORE, Dags Joan)	MARTHAN PRODUCT	111 Pe	nn Street	Balti	more. Ma	aryl	and 21201		
	DEC1 9 1994 Juli	SO KINGS CON . S. COLONIA	*							

TENDING PHYSICIAN: The law requires that the death certificate be executed within a flours after death. Page 6 may be retained by the hospital or attending physician.

THE After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should after this certificate has been signed by the attending physician and burial, cremation, or remond. BALTIMORE, MARYLAND 21215-0020 VISION OF VITAL RECORDS, P.O. BOX 68760,

	FOR
1	STATE
	REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

					10711		DEA	7 7 1	HEG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH MONTH DA	NY .	YEAR	. TIME OF DEATH
	Elsie Almond Dec. 17, 1994 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR F INDER 24 UNS. 7 DATE OF BIRTH. 18 BIRTHUR ACCURATE ALL PROPERTY									8:00 A M		
	4. SOCIAL SECURITY NUMBER	last birthday)				1 24 HRS.	7. DATE OF BIRTH (Month, Day Year)		(Country)	ACE (State or Foreign		
	220-30-0428	1 □ M 2 1 F	59	YRS.	WORLING.	UAYS	HOURS	Mirro.	(Month, Day, Year) Jan. 22,	1935	Virg:	inia
	9a. FACILITY NAME (# not institution, give s	street and number)			9b. CITY	9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH					ТН	
DIRECTOR	1400 Yeager Stre	et			Baltimore							
5					_							
	10s. STATE 10b. COUNT	Y		10c. CIT	Y, TOWN	OR LOCAT	TION				10	Od. INSIDE CITY LIMITS?
	Maryland Baltimore N∑ YES 2 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY									YES 2 NO		
A A						101	f. ZIP COO	_		_		AT COUNTRY?
	1400 Yeager Str	Y				L_			211		S.A.	
FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married	ARMEO NO	13.	WAS DEC	CENDENT (OF HISPAN	IC ORIGIN? (Specify Yes	or No-	14. RACE — Black, V	- American Indian, White, etc.		
BY	3 Widowed 4 Divorced	IF YES, GIVE V	WAR OR OATES			1 ☐ YES 2 X NO Specify: White					White	
ED E		CATION	1.0								<u> </u>	WILLE
Elementary/Secondary (0-12) College (1-4 or 5 +) (Give kind of work done during most of working life. Do NOT use retired.)								16b. KINO OF BUS	16b. KINO OF BUSINESS/INDUSTRY			
								White Coffee Pot				
W W	unknown 17. FATHER'S NAME (First, Middle, Last)			Manag	er						e rot	
									ME (First, Middle, Malden			
BE	Lawrence Hepner								ia Hansber			
2									Noute Number, City or Tow			1.1
	Valeria Becker							ватс	imore, Mar			
5	20a. METHOD OF DISPOSITION 1 Durial 2 Documenton 3 Rem	oval from State	cemetery,	CEAND DATE	OF DISPOS other place	SITION (NE	ame of	1.0			- City or Town	
	1 Burlet 2 to Cremetion 3 Removed from State Cemetery, cremetory or other place Green Mount Cemetery 12/20/94 Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY											
	1-4											
	A. Alan Seitz, Jr. Funeral Home 21211											
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									Approximate		
anock, or heart failure. List only one cause on/each line.										Interval Batwean Onset and Death		
	disease or condition	KESP	IRAT.	O RY	F	411	Lui	RE				
	reaulting in death)	DUE TO	(OR AS A CONS	SEOUENCE O	F):	Α.	0					
z		Co	PD	_ (/	EM		17	A	LE)			
IMMEDIATE CAUSE (Final disease or condition resulting in death) Note: The condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST LESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):												
§	cause. Enter UNDERLYING CAUSE (Disease or injury	C.										
E	that initiated eventa	DUE TO	(OR AS A CONS	SEOUENCE O	F):							
	resulting in death) LAST	d										
	PART II. Other significant condition	to contributing to	death but no	t regulting	In the se	ada di da		-1 1- 1	Part I. 24s. WAS AN			
EDICAL		- Continuating to	dadii bat iio	t readiting	in the ur	derryin	g cause :	given in	PERFOR		All	ERE AUTOPSY FINDINGS MILABLE PRIOR TO
ă									1 YE\$ 2	□ NO		OMPLETION OF CAUSE F DEATH?
Σ	DID TORACCO LISE	CONTRIBUTE	TO CAL	ICE OF	DEAT	PLI V	CC BC	NO			t	YES 2 NO
Z	DID TOBACCO USE	COMIKIBUIE	: IU CA	JSE OF	DEA	H Y	E2 🔀	NO				
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:			OTHE		LACE OF D	EATH (Che	ick only one)			
ΥS	1 TYES 2 NO	1 Inpatient 2		_	4 🗆 Nur	sing Horr	10 5 R	saldence	8 Other (Specify)			
표	27. MANNER OF OEATH 12 Natural 5 Pending	28s. DATE OF (Month, E		28b. TIN	JURY	WC	JURY AT ORK?		28d. DEŞCRIBE HOW I	NJURY OC	CCURED	
B	2 Accident Investigation				М		YES 2	NO				
	3 Suicide 8 Could not be 4 Homicide datarmined	28s. PLACE C building,	of INJURY — At atc. (Specify)	home, farm,	street, fact	lory, offic	ca .		28t, LOCATION (Street a City or Town, State)	and Numbe	or Or Rural Rou	te Number,
ETED	4 Homicide datermined											
12	29a. CERTIFIER 1 CERTIFYING PHYS	CIAN: To the best of	my knowledge,	death occurr	red at the t	lme, date	and place	, and due	to the cause(a) and mar	ner aa sta	nted.	
COMPL	one) 2 MEDICAL EXAMINE											nd manner as stated,
	296. SIGNATURE AND TITLE OF CERTIFIE	R					29c, LIC	ENSE NUM	BER	29d DA	TE SIGNED /M	fonth, Day, Year)
BE	Kaymond A.	Mizen	10 8	· A				12 1	101		10/	10/61
유	39 NAME AND ADDRESS OF PERSON WH	O COMPLETED CAU	SE OF DEATH (I	TEM 27) (Type	, Print)		1	10		-	~ 1 1	, , ,
	KAYMUNI) A. M	ZE MD.	PA.	780	14	OF	k K	DA	300, To.	nso	w M	021204
	31. OATE FILED (Month, Day, Year)	32. REGISTRA	AR'S SIGNATURE	-	_							
	DEC1 9 1994 4	his Davides	CRed-11									- 1

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FOR

DONNIE KUNTA Atkinson Dev 14 1994 4. SOCIAL SECURITY NUMBER 218 – 94 – 9526 1 XM² 2 F 17 VRS. BELOWER 1 YEAR FUND	MOTE Od. INSIDE CITY LIMITS? YES 2 TAP AT COUNTRY? A American Indian, White, atc. Black										
4. SOCIAL SECURITY NUMBER 218-94-9526 1. SEX 1. SE	ACE (State or Foreign MD) ATH MOTE Od. INSIDE CITY LIMITS? YES 2 TAP AT COUNTRY? A American Indian, White, atc. Black										
218-94-9526 IXPM 2	ACE (State or Foreign MD) ATH MOTE Od. INSIDE CITY LIMITS? YES 2 TAP AT COUNTRY? A American Indian, White, atc. Black										
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James A. Morton & Sons Fu 1701 Laurens St.	neral Ho										
IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. Gurshet We and of Right Hand and Head DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):	Onset and Deati										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN											
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28e. PLACE OF INJURY — At home, form, street, factory, office. 28f LOCATION (Street and Number of Russell											
4 Anmicide determined building, etc. (Specify) Home City or Town, State) 6 087 Barston Baltimore Co. HD	Rd										
29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as started. 27 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and	nd manner as stated,										
296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Mo	onth, Day, Year)										
Dernin & Chutz vo	5 1994										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
111 Penn Street, Baltimore, Marylan	nd 21201										

BALTIMORE, MARYLAND 21215-0020

TO THE PROGRAM OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within explorant leads. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 68760

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate the second without the model of the model of the second of the attending physician and completely filed in the second careful, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to be minimal or minimal. IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. 1300 FUTAL PL BALTO MD 21217										
ESTEP BROTHERS FUNERAL HOME P.A.										
23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardled or respiratory strest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Approximate interval Between Onset and Death Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
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29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Moort, Agr. 1944) 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 21) Gyps, Print)										
31. DATE FILED (Month, Day, Year) DEC1 9 1994 Julya Dayselford	_									

BALTIMORE, MARYLAND 21215-0020

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

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	- 1	MONTH DAY YEAR										TIME OF DEATH TEST PM			
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PHYSICI, this cert with the	PHY	27. MANNER OF DEATH		28a. DATE OF (Month, D			28b. TIME INJU	OF 2	8c. INJ	JURY AT ORK?	-	28d. DESCRIBE HOW	NJURY OCCU	JRED	
DING PHYS After this of death with s marked	ВУ		Pending Investigation	199				M		YES 2 N	NO				
TTENDIN TOR: Aft after de	0		Could not be	28a. PLACE O building,	etc. (Special	— Al home	e, farm, st	reet, factor	y, offic	ea .		28f. LOCATION (Street City or Town, State)	and Number o	or Rural Ro	ite Number,
L OR ATTENDING P DIRECTOR: After the hours after death vitem 28 is mark	ETE		detarmined						_	·					
4 7 2 = 1	COMPLE	anal										the cause(a) and ma			
TO THE HOSPITAL TO THE FUNERAL I BE filed within 72 h IMPORTANT: IF I	Š	2 MEDI	CAL EXAMINE	R: On the basis of a	camination	and/or Im	restigstion	, in my opi	nlon, d	festh occured	at the ti	me, data and place, ar	d due to the	cause(a)	and manner as stated.
H H H B B W T W D B W T W D B	BE (296. SIGNATURE AND TITLE	OF CERTIFIER		_					29c. LICENS			29d. DATE	SIGNED (Aonth, Day, Year)
5 5 3 W	0	10	pen		-					D 3	37	435	> \	5/11	144
		JOSEPH KAN		COMPLETED CAUS	SE OF DEA	TH (ITEM	27) (Type, I	Print)	n	OWE	۲,	wo 508.	35		
		31. DATEPINED THE OTHER		aha dhush	n's sign	TURE			100		(,				
		DECT 9	004	ALONA, BURUSHI	WOLKIN	walk									
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BALTIMORE, MARYLAND 21215-0020	The inverse of the death certificate be executed within a froms after death. Page 6 may be retained by the hospital or attending physician.	scrifting hear signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.	he medical examiner must be notified at once.
DIVISION CEVITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING PRINCIPAL IN CAQUIES that the death certificate be executed within	TO THE FUNERAL DIRECTOR: Air this certificat heat been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the filed within 72 hours after death with the filed within 72 hours after death with the filed within 72 hours after death with the filed within 72 hours after death with the filed within 72 hours after death with the filed within 72 hours after death with the filed within 12 hours and filed in by the filed within 12 hours after death withi	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

-	REGISTRAR			CERTIF	ICALE	UF	DEAL	I II		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)				-				2. DATE	OF DEATH			3. TIME OF DEATH
	Anna Ev	zelyn Ber	nett					ŀ	Тоом		6, 1	YEAR QQ/i	3 P. M
	4. SOCIAL SECURITY NUMBER	5. SEX		s. last birthday)	IF UNDER	1 YEAR	IF UNDER			OF BIRTH	.0, 1		IPLACE (State or Foreign
- 0	215 14 2002	1 M 2XXF		YRS.	MONTHS	DAYS	HOURS	MIN.	(Mont	th, Day, Year)		Countr	γ)
	215 14 2982		85							z 26, 1	.909		yland
~	9e. FACILITY NAME (If not institution, give st	reet and number)			9b. CITY,	TOWN (R LOCATIO	ON OF DE	ATH		9c. COU	NTY OF D	EATH
0	6504 Sykesville F	Road			Sī	rkes	vill	0			l c	arro	11
DIRECTOR													
2	10e. STATE 10b. COUNTY				Y, TOWN O		ION						10d. INSIDE CITY LIMITS?
ā	Md. Carro	011		Syk	esvi]	Lle							1 YES TO NO
4	10e. STREET AND NUMBER					101	ZIP CODE				10g. CIT	ZEN OF W	VHAT COUNTRY?
FUNERAL	6504 Sykesvill			12	1784			U.S.A.					
Z I	11. MARITAL STATUS	12. WAS DECEDEN	T EVED IN II	APMED					10 00.01	N? (Specify Yee			
	1 Never Married 2 Merried	FORCES? 1	NO	1	f yes, sp	ecify Cube	n, Mexican	n, Puerto	Rican, atc.)	or No-	Black	— American Indian, c, White, etc.	
B	3 🖔 Widowed 4 🗌 Divorced	ES 1 ☐ YES 2 🔯 NO Specify:					Specify:						
							White NT'S USUAL OCCUPATION 166. KIND OF BUSINESS/INDUSTRY						е
	(Specify only highest grade	completed)		(Give kind of a	work done o			g	160	I KIND OF BUS	INESS/INL	JUSTRY	10
ات	Elementary/Secondary (0-12)	College (1-4 or 5 i			M. Saraha					0 0	T) [11]		
E	7		T	elepho	ne U	pera	tor			U 8	PT	етер	hone Co.
COMPLETED	17. FATHER'S NAME (First, Middle, Last)						18. MOTE	HER'S NAM	ME (First,	Middle, Meiden	Sumame)		
BE	John Smith						Ge	orgi	a A	Beacra	ıft		
	19e. INFORMANT'S NAME (Type/Print)			19b. MAILING	ADDRESS	(Street e	nd Number	or Rural A	Route Num	ber, City or Town	n, State, Zic	Code)	
임	Ruby Belle Richard	ison		1302	2 010	i Ha	nove	r Rd	. Re	eisters	town	. Md	. 21136
	20a. METHOD OF DISPOSITION		20h PL	ACE AND DATE		_			DAT	-		City or To	
	1 N Buriet 2 Cremetion 3 Remo	oval from State	cemeter	y, cremetory or o	ther place)								
	21. SIGNATURE OF FUNERAL SERVICE LIG	event /	01d	<u>Oaklan</u>						1994 5	ykes	vill	e, Md.
	21. SIGNATURE OF PUREAU SERVICE EN	Haust	1		22.1	NAME AN	ID ADDRES				-		
	- Quan or	. Theye	A			0 0	1			ht Fun			
	23. PART I. Entar tha diseasea, or c	omplications that	caused the	e death. Do i	not anter	tha mo	da of dvi	ng auch	vkes	ville.	Md.	21/	Approximate
	ahock, or haart fallure. I	lat only one cau	se on each	lina. *	-	-		g, aacı		arao or roupi	atory arr	000	Interval Between
1	IMMEDIATE CAUSE (Final	MA OFFE	ofat	20	han		1	1444.6	ON				Onset and Daath
disease or condition resulting in death) a. Motastatic braw							1		<u>.</u>				
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Modes and C brain to DUE TO (OR AS A CONSEQUENCE OF): Prim Sequentially list conditions b.						ary	1 l	unKho	our	-	dans		
						l	ι				n 0 .		
ĔI	Sequentially list conditions, If any, leading to Immediate DUE TO (OR AS A CONSEQUENCE OF):												H) WOW
CERTIFICATION	CAUSE (Disease or Injury												00
	that initiated eventa	DUE TO	(OR AS A CO	NSEQUENCE O	F):								
H	resulting in death) LAST	l											
	DART II Other sleetflees and date												
EDICAL	PART II. Other significant conditions	DI SOR	daath but r	not resulting	n tha un	derlying	causa g	lven in F	Part I.	24s. WAS AN . PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
용Ⅱ	HOSTIC VILLE	MISOR	20 <	7 (7	D	<u>4</u>	H	VV		1 TYES 2	TIMO		CDMPLETION DF CAUSE OF DEATH?
₩													1 YES 2 THO
2	DID TOBACCO USE CONTR	BUTE TO CA	LISE OF T)FΔTH VE	S \square k	JO [LINC	ERTAIN					
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	DOIL TO CA		PLACE OF DEAT			DIAC	FUIVIII	,				
	EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER	1:							
<u>¥</u> ∥	27. MANNER OF DEATH	1 inpatient 2 28e. DATE OF			· · · · · · · · · · · · · · · · · · ·		5 🗆 Re						
ᆲ	1 Natural 5 Pending	(Month, Di	ny, Your)	28b. TIM	URY	28c. INJ	RK?		28d. DES	SCRIBE HOW IN	IJURY OC	CURED	
ׄאַ	2 Accident Investigation				М	1 🗌 1		NO					
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE Of building,	F INJURY — / ntc. (Specify)	At home, term,	dreet, lecto	ory, office	•			ATION (Street a or Town, State)	nd Number	or Rural R	loute Number,
	4 Homicide determined												
۱۱ ۵	290. CERTIFIER (Check only	IAN: To the best of	my knowledge	e, death occum	ed at the tie	me, date	end place.	end due t	to the car	use(s) end men	ner ee atat	ed.	
OMPLETED	one) 2 MEDICAL EXAMINER) end menner ee stated.
ၓ	29b. SIGNATURE AND TITLE OF CERTIFIER	-								2000 000 00			
	296. SIGNATURE AND TITLE OF CENTIFIER	2 805)			l	29c. LICE	NSE NUMI	3014	<u> </u>	29d. DAT	E SIGNED	Month, Day Year)
0	Kroamour.	t						1 4 -	~!	,	P	14	11177
- 1	30. NAME AND ADDRESS OF PERSON-WHE	COMPLETED CAUS		(ITEM 27) (Type,	Print)	7	A 1 4	10	0	1	-	, 75	- Md -
	MINESIL 2. VIL	AKIM	217		MIM	4/0	iv t	101-	7	WES	(MI)	V >1 (K, 715)
	31. DATE FILED (Month Day Year)	324 REGISTRA	R'S GNATUI	72									
	DEOT 9 1084	No. In the Case		•									

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within to the relating of may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

It	em # 1 Film # G 718 12-19	J-94 N.A. Per Fun	neral Home			94	37388		
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND /		T OF HEALTH AND E OF DEATH	MENTAL HYGIEN				
OR	1. DECEDENT'S NAME (First, Middle, Lest) BC KP Ch 4. SOCIAL SECURITY NUMBER 212-163658	SEX 6. AGE (in yrs. lest	Charles E		2. DATE OF DEATH DOWNTH DOWNTH DOWNTH DOWNTH (Month, Day, Year)	AY 94 YEAR	THPLACE (State or Foreign intry) Hd		
ERAL DIRECTOR	10a. STATE 10b. COUNTY 10a. STATE 10b. COUNTY 10a. STREET AND NUMBER	INC.	10c. CITY TOWN	101. ZIP CODE		10d. INSIDE LIMITS? 1 ✓ YES 2 10g. CITIZEN, OF WHAT COUNTR			
BY FUNERAL	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. ARI FORCES? 1 YES 2 N IF YES, GIVE WAR OR DATES	10	Was DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 NO Specif	NIC ORIGIN? (Specify Year, Puerto Rican, etc.)	Bi	ACE — American Indian, ack, White, alc.		
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Factory 17. EATHER'S NAME (First, Middle-Apst)								
TO BE CO	Kabert Baker 19a. INFORMANT'S NAME (Specifini) Leva Black	190	SEC E	Secon field	AME (First, Middle, Meiden M / Y Route Number, City or Tow	h			
	20a. METHOD OF DISPOSITION 1			SITION (Name of Forest Utt.) NAME AND ADDRESS OF FAMOUR FOR FAMOUR FAMOUR FOR FAMOUR FOR FAMOUR FOR FAMOUR FOR FAMOUR FOR FAMOUR FOR FAMOUR FOR FAMOUR FAMOUR FOR FAMOUR FAMOUR FOR FAMOUR FA	3/19/94 (Ju	CATION - CHY OF	Town, State 1// Ly 12		
	23. PART Enter the diseases, or commonly the common to t		eth. Do not enle		ch ea cardlac or reap		Approximata Interval Between Onset and Death		
PHYSICIAN: MEDICAL CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. INELLY ON CONSEQUENCE OF): C. COUNCE TO (OR AS A CONSEQUENCE OF):								
	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO								
AN: N	DID TOBACCO USE CO	NTRIBUTE TO CAUS	SE OF DEA				1 TYES 2 NO		
SICI	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	OSPITAL:	DOA 4 Nu	28. PLACE OF DEATH (C) R: Irsing Home 5 Residence					
ву РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	28c. INJURY AT WORK?	28d. DESCRIBE HOW	NJURY OCCURED				
	3 Suicide 8 Could not be detarmined	and Number or Rura)	al Route Number,						
COMPLETED	onel	N: To the best of my knowledge, dai					e(s) and menner as stated.		
O BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	3MD Madic	al Resi	ALT POG			ED (Month, Day, Year)		
	TO NAME AND ADDRESS OF DEDSON WAS C								

DID TOBACCO USE	CONTRIBUTE TO CAUS	DE OF DEA	ATH YES [] N	40 🗌
25. WAS CASE REFERRED TO MEDICAL			28. PLACE OF DEATH	
1 YES 2 NO	HOSPITAL: 1 Dippetiant 2 ER/Outpetiant 3	DOA 4 N	ER: ursing Home 5 Residen	nce 8 Other (Specify)
27, MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME OF	28c. INJURY AT	28d, DESCRIBE HO

 20. PLACE OF DEATH						
HOSPITAL: 1 Department 2 ER/Outpatient 3	□ DOA	OTHER: 4 Nursing Home 5 Ra		Rasidenca		
28a. DATE OF INJURY	28b. TIA	E OF	28c. INJURY	T		

□ NO	28d. DESCRIBE HOW INJURY OCCURED	
	281. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

494	. CENTIFIER	. [CERTIFYING PHYSICIAN, T. A. S. S. S. S. S. S. S. S. S. S. S. S. S.
	(Check only		CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
	one)	2	MEDICAL EXAMINER: On the basis of exemination and/or importantian in my pololog death account at the time date and along and the time.

2 MEDICAL EXAMINER:	On the basis of examination and/or investigation, in my opini	on, death occured at the time	, data and place, and due to t	he cause(s) and menner as stated.

Call (1111) Wille	ICCUL NOSCH		Wace		/	1	111	49	
RESS OF PERSON WHO COMPLETED CAUSE OF DEATH						-	t	1	
EFRANTHUD	RVAMO	100 01	1	01	>	11 1	. 1	2	-

DEC 1 9 1994 32. REGISTRAR'S SIGNATURE

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OR TATE	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIEN
GISTRAR	CERTIFICATE OF DEATH REG. NO.

		FOR STATE REGISTRAR	STATE OF MARYLA	AND / DEP/ CERTI	ARTMENT OF	HEALTH AND F DEATH		TYGIENE REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last) Lewis S	Beasley	_			2. DATE OF MONTH		3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER		n yrs. last birthda		IF UNDER 24 HRS.	7 DATE OF	виоти Т	B. BIRTHPLACE (State or Foreign
p _i n		225-05-7730 90. FACILITY NAME (If not institution, give s	17€XM 2 □ F 9 4	4 YRS					irginia
2, 3 should	OR	26 Hobart Court	reac and number)			or location of D .lstown	EATH	Balti	Y OF DEATH
es 1.	DIRECTOR	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY		10c. 0	STY, TOWN OR LOC	ATION			10d, INSIDE CITY
nit. Pag		Maryland Balti	more		Randal				LIMITS?
or per	FUNERAL	100. STREET AND NUMBER 26 Hobart Court			1	101. ZIP CODE 21133		10g. CITIZE	EN OF WHAT COUNTRY?
O sician. ial-tran	UNE	11. MARITAL STATUS	12. WAS DECEDENT EVER IN			ECENDENT OF HISPA			U.S.A. 4. RACE — American Indian,
21215-0020 all or attending physician, for use as the burial-transit permit. Pages 1, 2,	ВУ	1 Never Merried 2 Merried 3 Wildowed 4 Divorced	FORCES? 1 YES	2 NO		specify Cuben, Mexic ES 2 X NO Speci		n, etc.)	Black, White, atc. Specify: White
21215- al or attendi for use as	COMPLETED	15. DECEDENT'S EDU (Specify only highest grade		(Give kind	'S USUAL OCCUPAT of work done during in use retired.)	TION most of working	16b. KIP	D OF BUSINESS/INDU	
W = 5	F	Elementary/Secondary (0-12)	College (1-4 or 5+)		inter		Home	e Improvem	ent.
AND the hospit detached	SON	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA		le, Maiden Surneme)	
MARYLAND 2 retained by the hospital 5 should be detached to	BE	Richard Beasl 190. INFORMANT'S NAME (Type/Print)	ey			Fannie		leman	
	5	Edith Jones						city or Town, State, Zip Com, Md 211	
ORE, e 6 may be ector, page must be		20a. METHOD OF DISPOSITION 1 Source 2 Cremetion 3 Remo	20b. ceme	PLACEANDDAT	E OF DISPOSITION //	Neme of	DATE	20c. LOCATION — CI	ty or Town, State
Page 6		4 Donetion 5 Other (Specify)		olly Hi	11 Mem.	AND ADDRESS OF FA	CILITY		County, Md
BALTIMORE, ler death. Page 6 may be the funeral director, page and.		(Denut &	Springer	roler	BRUZ	DZINSK FU	NERAL	HOME P.A.	aryland 21221
ic at		23. PART I. Enter the diseases, or cahock, or heart failure.	omplications that caused List only one cause on ea	the death. Do	not enter the m	node of dyling, suc	ch as cardiac	or respiratory arres	at y Land 2 22 st, Approximate Interval Between
# 10 m =		iMMEDIATE CAUSE (Final disease or condition			oti Car	100 3950	0017	D176090	
ted within completely filler ial, cremation, event, the		resulting in death)	DUE TO (OR AS A	CONSEQUENCE	OF):	4.00,000		C 12 C C C C C C C C C C C C C C C C C C	المعمول ا
68 and and o bur	<u>0</u>	Sequentially list conditions,	DUE TO (OR AS A	CONSEQUENCE	OF):				,
9 6 8 6 P	CAT	If any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or Injury							
certific reding p Hygiene	CERTIFICATION	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE	OF):				
0 2 3 3		PART II. Other significant condition	a contributing to death bu	it not resultin	a in the underlyi	ng cause given in	Part I 24	a. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
ORE that the ed by th and any in	JICAL					- Jacob great in		PERFORMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
RECOF w requires that been signed to to of Health a	MEDIC/							•	1 TES 2 NO
2 2 2	PHYSICIAN:	DID TOBACCO USE CONTI			YES NO [N 🗆 📗		
는 후 을 등 등	SIC	EXAMINER?	HOSPITAL: 1 Inputlent 2 ER/Output		OTHER:	me 5 Residence	8 Dother (Sp	pecify)	
OF V	E	27. MANNER OF DEATH 1 Natural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)		NJURY W	NJURY AT YORK?	28d, DESCRI	BE HOW INJURY OCCU	RED
/ISION OF VI: ATTENDING PHYSICIAN: CONT. THE CONTING THE STATE OF IT	3	2 Accident Investigation 3 Suicide 8 Could not be	28e. PLACE OF INJURY	— At home, farn		YES 2 NO	281. LOCATIO	N (Street and Number or	Rural Route Number,
DIVISION OR ATTENDING	2	4 Homicide determined	building, etc. (Specia	······			City or To	own, Stete)	
작 극이 는	MPL		CIAN: To the best of my knowle						
THE HOSPITAL THE FUNERAL filed within 72 PORTANT: II	COM	29b. SIGNATURE AND TITLE OF CERTIFIER	. On the basis of exemination	end/or investiga	mon, in my opinion,	29c. LICENSE NU			ceuse(e) end menner as stated. SIGNED (Month, Day, Yeer)
TO THE HOSPIT TO THE FUNERA De filed within 7 IMPORTANT: I	H	In Hopela	Quo			72703	9	▶ /	21594
8	임	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEA			0 11	1 7/4	10 422	
U		31. DATE FILED (Month, Day, Year)	5310 OLU	WIF K	ad Suite 20	1 Randall	STOWN/M	021135	
	I	31. DATE FILED (Month, Day, 18ar) DEC1 9 1994	M COMMISSION NOW	44					

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1 - FOR STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH 1994 EDITH CATANIA December 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS 1 M 2 X F YRS. 215-76-2448 68 November 27, 1926 Maryland 9e. FACILITY HAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 104 Hillendale Road BelAir Harford RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. IHSIDE CITY Maryland Harford BelAir 1 YES 2 X NO permit. 10e. STREET AND HUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? for use as the burial-transit 104 Hillendale Road 21014 United States Page 6 may be retained by the hospital or attending physician. WAS DECENDENT OF HISPAHIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerio Rican, atc.)
 Hyes, specify Cuban, Mexican, Puerio Rican, atc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO If yes, specify Cuben, Mexican, Puerto Ri 1 YES 2 X NO Specify: 1 Never Married 2 X Married IF YES, GIVE WAR OR DATES ΒY 3 Widowed 4 Divorced Specify: White COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIHD OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) ntary/Secondary (0-12) College (1-4 or 5+) funeral director, page 5 should be detached 8 Homemaker 17. FATHER'S HAME (First, Middle, Last) 18. MOTHER'S HAME (First, Middle, Maiden Surname) Ħ Howard J. Walters Edith Mumma BE notified 19a. INFORMANT'S HAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Mr. Francis S. Catania 104 Hillendale Road BelAir, Md. 21014 9 20s. METHOD OF DISPOSITIOH
1 X Burtal 2 Cremetion 3 Removel from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata DATE must Most Holy Redeemer Cemetery 12/19/94 4 Donation 5 Other (Specify) Baltimore, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna examiner 22. NAME AND ADDRESS OF FACILITY
Leonard J. Ruck, Inc. male T. filled in by the fullon, or removal. 5305 Harford Road 21214 Baltimore.Md. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, medical Approximata shock, or heart fellure. List only one ceuse on each line. interval Between IMMEDIATE CAUSE /Final completely filled Onset and Death of LUNG the disease or condition ADENOCACINOMA

DUE TO (OR AS A COHSEQUENCE OF): MON resulting in death) event. executed with bunal, traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) prior to if any, leading to immediate cause. Enter UNDERLYING the attending physician Mental Hygiene prior to CAUSE (Diseese or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY MEDICAL 24b. WERE AUTOPSY FINDINGS signed by the RECTAL CANCER AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? HISTWY of any 1 YES 2 W NO Shows 1 YES 2 NO has been s Dept. of H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) this certificate h OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) the the 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c, INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED marked. 1 A Natural 5 Pending Investigation M 1 YES 2 HO BY After t death 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) DIRECTOR: A hours after d litem 28 is 3 Suicide 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE FUNERAL OF THE INTERPRETATION OF THE INTERPRETANT. IT IN PHEGHOSPITAL (Check only one) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 2 HE AND TITTLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, De BE 12 16 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) BELAIR 32. REGISTRAR'S SIGNATURE D'AUGUELLAN ROMANIA 31. DATE FILED (Month, Day 9 1994

Item#1 Per F.H. Film# G-718 12/19/94 R.M.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BALTIMORE, MARYLAND 21215-0020	The me requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician.	Lenn and he signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be the best of Health and Mental Hygiene prior to burial, cremation, or removal.	nedical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OR ATTENDING AND THE WAS THE WAS THE CONTINUED TO STATE OF ATTENDING AND THE MITHIN 2-17	TO THE FUNERAL DIRECTOR: For the comment has been signed by the attending physician and completely filled in by the it be filed within 72 hours after completely filled in by the 1 be filed within 72 hours after completely filled in by the 1	IMPORTANT: If Item 28 is marked, as new 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

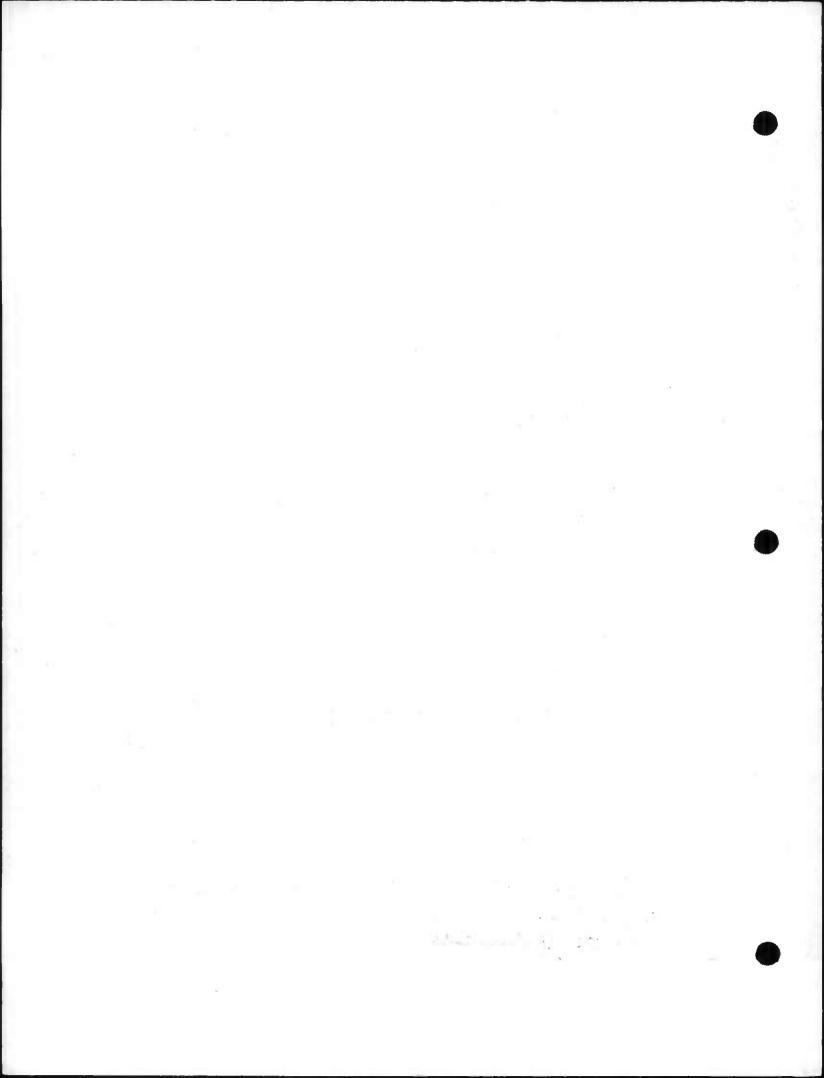
1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
	1. DECEDENT'S NAME (First, Middle, Last) Viola Cat	herine Caspe				2. DATE OF DEATH	year 5:30 a.m.		
	4. SOCIAL SECURITY NUMBER 388-44-0783	1 🗆 M 2 📆 🖟	(In yrs. lest birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	B. BIRTHPLACE (State or Foreign Country) Wisconsin			
LOR	99. FACILITY NAME (If not institution, give so Chapel Hill N				OR LOCATION OF D		9c. COUNT	Y OF DEATH	
CTO	RESIDENCE OF DECEDENT				lallstown			Baltimore	
DIRECTOR		timore	7.55	y, town on Loca Reisters				10d, INSIDE CITY LIMITS? 1 YES 2 KNO	
FUNERAL	100. STREET AND NUMBER 11202 Th	ompson Ave.		10	21136		U.S.	A .	
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER II FORCES? 1 _ YES IF YES, GIVE WAR OR D	2 NO	If yes, ar	ENDENT OF HISPAI ecity Cuban, Maxics 2 NO Specif	NIC ORIGIN? (Specify in, Puarto Rican, etc.) y:	Yes or No.— 1	4. RACE — American Indian, Black, White, etc. Specify: White	
ETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	ICATION completed) College (1-4 or 5+)	(Give kind of t	ECEDENT'S USUAL OCCUPATION Give kind of work done during most of working e. Do NOT use retired.)					
COMPLET	12 17. FATHER'S NAME (First, Middle, Last)	4	Teac	cher				& College	
	William K	ennedy				ME (First, Middle, Meld Catherine			
TO BE	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural	Route Number, City or	Town, State, Zip C	ode)	
-	Barbarh Clari					Reisters			
	20s. METHOD OF DISPOSITION 1 A Buriel 2 Cremation 3 Ram 4 Donation 5 Other (Specify)	I	PLACEAND DATE (petery, crematory or o	cemete	ry Dec.	21, 1994	LOCATION — CH Westfor	rd. Wisconsia	
	21. SIGNATURE OF FUNERAL SERVICE LIC	bladt		Eckh	ardt Fun	eral Chap estown Pd	el Owing	21117	
	23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due To (or as a consequence on:								
CERTIFICATION	Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Due TO (OR AS A CONSEQUENCE OF): c. Due TO (OR AS A CONSEQUENCE OF): d								
BY PHYSICIAN: MEDICAL (PART II. Other significant condition Diverties 4: 20/2	na contributing to deeth b	ut not resulting i	in the underlyin	g ceuse given in	PERF	AN AUTOPSY ORMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?				ACE OF DEATH (Ch	eck only one)			
YSI	t TYES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp	atient 3 DOA	OTHER:	e 5 🗆 Residence	8 Other (Specify)			
E .	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a, DATE OF INJURY (Month, Day, Year)	28b. TIM INJ	URY WO	URY AT PRK? YES 2 NO	28d. DESCRIBE HO	W INJURY OCCU	9ED	
	3 Suicide 8 Could not be determined	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm, s	street, factory, offic	•	281. LOCATION (Stree City or Town, Sta	et and Number or nte)	Rural Route Number,	
COMPLETED		ICIAN: To the best of my knowl R: On the basis of examination						Couse(s) and manner as atated.	
8	296. SIGNATURE AND TITLE OF CERTIFIES	Mon			29c. LICENSE NUM	ABER P71	29d, DATE S	RIGNED (Month, Day, Year)	
٩	30. NAME AND ADDRESS OF PERSON WH	and the same of th	ATH (ITEM 27) (Type,	Driv.			11 /00	~n, Md	
	DECT 9 1994	22 RESISTRAP SIGN	ATURE					2/136	

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BALTIMORE, MARYLAND	nours after death. Page 6 may be retained by the hosp	ed in by the funeral director, page 5 should be detached	medical examiner must be notified at once.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OF APPLICANE THE ISSUANCE THE law requires that the death certificate be executed within about after death. Page 6 may be retained by the hosp	TO THE FUNERAL CHEECOR After a curricate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached	De filed within 72 per commitment of the period of the per	
NOTSIAID	TO THE HOSPITAL OR APPLICATIONS #	TO THE FUNERAL DIRECTOR ATTE	IMPORTANT: II Item 28 Is man	

	1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG, NO.									
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	200	3. TIME OF DEATH				
	KEVIN LAMONT CALAMAN				Dec. 18	1994	2:15 AM			
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yr.	TOWARD OF THE STATE OF BIRTH								
		33 YRS. MO	NTHS DAYS	HOURS MIN.	6-12-61	Count	MD			
	9e. FACILITY NAME (If not institution, give street and number)	9b	CITY, TOWN O	R LOCATION OF DEA	TH	9c. COUNTY OF D	EATH			
6	Stella Maris	D	ulane	y Valle	У					
딦	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		OWN OR LOCAT				10d. INSIDE CITY			
DIRECTOR	MD		imore	011			LIMITS?			
	10e. STREET AND NUMBER			ZIP COOE		10g. CITIZEN OF WHA				
ER/	1219 Myrtle Ave.			21217			USA			
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S				C ORIGIN? (Specify Yee or		E — American Indien,			
	1 Never Married 2 Merried FORCES? 1 YES & IF YES, GIVE WAR OR DATES			city Cuban, Maxican,	Puerto Rican, etc.)	Spec	k, White, atc.			
BY							Black			
COMPLETED	15. DECEDENT'S EDUCATION 184 (Specify only highest grade completed)	(Give kind of work life. Do NOT use re	JAL OCCUPATIO done during mos	N t of working	16b. KIND OF BUSIN	ESS/INDUSTRY				
٦	Elementary/Secondary (0-12) College (1-4 or 5+)	Waiter	ениа.)		(Hotel)	Hvatt	Regency			
× I	17. FATHER'S NAME (First, Middle, Last)	101001		40 1407145010 1444	E (First, Middle, Maiden Su		Regency			
	Wallace Calaman				etta Mart					
BE	19s. INFORMANT'S NAME (Type/Print)	19b. MAILING AD	DRESS (Street er		etta Malt oute Number, City or Town,					
입	Henrietta Martin	ı			alto. MD	21217	7			
		ACE AND DATE OF D	ISPOSITION (Ne			TION — City or To				
		y, cremetory or other		a 1	12-23 Ba	ltimor	e, MD			
	21. SIGNATURE DIFFUNERAL SERVICE LICENSEE	THE SHOULD IT WILL IN THE SHOULD IT WILL IN THE SHOULD IT WILL								
	A Marta		Jam	es A. M	orton & S	Sons Fu	neral Home			
	23. PART I. Enter the diseases, or complications that caused the	e deeth. Do not	enter the mod	Laure	as cerdiac or respira	tory arrest.	Approximate			
- 1	shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and									
	disease or condition resulting in death)						2 ws			
	DUE TO (OR AS A CO	NSEQUENCE OF):					1 9			
Z	Commendative that any attitude of the comment of th									
CERTIFICATION	Sequentially list conditions, If any, leading to immediate									
일	CAUSE (Disease or injury									
	thet initieted eventa DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST									
CE	d									
AL	PART II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PREFORMEO? AMAILABLE PRIOR TO									
8					_ 1 U YES 275	CHO	COMPLETION OF CAUSE OF DEATH?			
¥	DID TOPACCO LICE CONTRIBUTE TO CO	LUCE OF F			′ ج		1 TES 2 NO			
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CA	AUSE OF E			DZI					
i i	EXAMINER? HOSPITAL:		THER:	ACE OF OEATH (Chec						
14S	1 YES 2 NO 1 Inpatient 2 ER/Outpatient 27. MANNER OF DEATH 280. DATE OF INJURY	28b. TIME OF		5 Residence 8	X) Other (Specify) 28d. DESCRIBE HOW INJ	Hospice	2			
	Natural 5 Pending (Month, Day, Year)	INJURY	WOI 1 Y	RK?	200. DESCRIBE NOW INS	ONT OCCUREO				
9	2 Accident Investigation 3 Suicide a Could not be building sto (Specific)	At home, ferm, atree			281. LOCATION (Street and	i Number or Rural I	Route Number,			
COMPLETED	4 Homicide datermined building, atc. (Specify)				City or Town, State)					
٣	29e. CERTIFIER (Check only	e, death occurred a	t the time date	and place, and due to	o the cause(s) and mana-	ar an etelad				
Š	(Check only one) 2 MEDICAL EXAMINER: On the basis of examination en						e) end menner ee stated.			
	29b, SIGNATURE AND TITLE OF CERTIFIER		Т	29c. LICENSE NUME			77 - 71 - 71 - 71 - 71 - 71 - 71			
BE	Kendago Dagenol	11 211	$_{\alpha}$	Dana	4-3	PLO /19	(Month, Day, Year)			
임	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	(ITEM 27) (Type, Prir	71)	.5000	()	.0/1	777			
				D., TOWS	ON, MD 21:	204				
	31. DATE FILED (Month, Day, Year) 32 REGISTRAR'S GNATU									
	DECI 91994 Juli Divoler Kardel	1 0.								



has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should use bept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND N	MENTAL HYGIENE
CERTIFICATE OF DEATH	REG. NO.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
	1. DECEOENT'S NAME (First, Middle, Lest) Catherine Lucille Glose 2. DATE OF DEATH MDECEMber* 17, 1994.3. TIME OF DEATH								
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 1 M 2 X 68 YRS. 6. AGE (In yrs. last birthday) 1 M ONTHS DAYS HOURS MIN. 7. DATE OF BIRTH Countril Aryland 6. BIRTHPLACE (State or Foreign Countril Aryland								
TOR	9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH Baltimore RESIDENCE OF DECEMENT								
DIRECTOR	10e. STATE Maryland 10b. COUNTY Baltimore 10c. CITY, TOWN OR LOCATION ESSEX 10d. INSIDE CITY LIMITS? 1 Uses 2 1 No								
FUNERAL	106. STREET AND NUMBER 107. ZIP CODE 109. CITIZEN OF WHAT COUNTRY? 27.227 USA								
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECEMENT OF HISPANIC ORIGIN? (Specify Yea or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 15. WAS DECEMENT OF HISPANIC ORIGIN? (Specify Yea or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 16. WAS DECEMENT OF HISPANIC ORIGIN? (Specify Yea or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.)								
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Steel Mill Steel Mill								
BE COM	17. FATHER'S NAME (First, Middle, Last) Isaac W. Bell 18. MOTHER'S NAME (First, Middle, Melden Surname) Estelle Bast								
2 2	196. INFORMANT'S NAME (TypesPrint) Emmett F. Howard 19b. Mailing Acoress (Street and Number or Rural Route Number, City or Town, State, Zip Code) 122 Dihedral Dr. Baltimore, MD 21220								
	20a, METHOD OF DISPOSITION 1 Gentler 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Cermetery, Oaker Lawre-Cemetery) 20c. Location - City or Town, State 22/19 94 Baltimore Co., MD								
	21. SIGNAPURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home PA 1407 Eastern Ave. Baltimore. MD 21221								
	23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List pnly one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	Sequentially list conditione, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST b. OUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF):								
MEDICAL C	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO COMPLETION DE CAUSE OF DEATH? 1 YES 2 NO								
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)								
PHYSICIAN:	#OSPITAL: 1 YES 2 NO 1 Inpettant 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Refidence 6 Other (Specify) 27. MANNER OF DEARTY 286. OATE OF INJURY (Month, Day, Year) 286. INJURY T WORK?								
ED BY	S Pending Investigation Investigation Suicide 6 Could not be 28a. PLACE OF INJURY — At home, term, street, tectory, office building, atc. (Specify) 28b. PLACE OF INJURY — At home, term, street, tectory, office could not be building, atc. (Specify)								
COMPLETE	29e. CERTIFIER (Check only 1 DEERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.								
BE CON	2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Fronth, Day, Year)								
0	30. NAME AND ADMINIST OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
	MYO THANT 9101 FRANKLIN SO - DX, BHLTU, MD 21237 31. DATE FILED (Morith, Day, Volar) DEC1 9 1994 July Dawdler Randoll								

The Mark Hall

BALTIMORE, MARYLAND 21215-0020	irs after death. Page 6 may be retained by the hospital or attending physicia
	hin 24 hours after d
BOX 68760	ate be executed wit
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	NDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
F VITAL RE	YSICIAN: The law requi
DIVISION	OR ATTENDING PHY

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

	20110						94	J	1334		
	FOR 1 - STATE REGISTRAR	STATE OF MARYLAN		TMENT OF H		MENTAL HYGIEN					
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	·		3. TIME OF DEAT	Н	
1	VERNON I	ROBERT	COU	SINS		MONTH E	5	94			
			rs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	5		0440 PLACE (State or Fo	A M	
FUNERAL DIRECTOR	10 1/	ŒM2□F 46	M 2 DF 46 YRS. MONTH			July 13"]	Mar	yland	gri		
	98. FACILITY NAME (If not institution, give street NORTH ARUNDEL HO	₹.	ANNAP	DLIS	EATH	ARUNDEI					
5	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY										
DIRE		imore	10c. CITY	TOWN OR LOCAT					10d. INSIDE CITY LIMITS?	NO	
7	10e. STREET AND NUMBER			101	. ZIP CODE		10g. CIT		HAT COUNTRY?		
ER.	1734 Hilltop	Rd.			2122	1			SA		
5	11. MARITAL STATUS	WAS DECEDENT EVER IN U. FORCES? 1 YES	S. ARMED	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (Specify Ye	s or No-	14. RACE	- American India	in,	
BY	1 Never Married 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR DATE:	BNO	π yes, sp.	2 NO Specif	nn, Puerto Rican, etc.) y:		Specify	- American India White White	•	
	15. DECEDENT'S EDUCATION	ON 16	. DECEDENT'S I	USUAL OCCUPATION	ON .	16b. KIND OF BU	SINESS/INI	DUSTRY			
COMPLETED	(Specify only highest grade con Elementary/Secondary (0-12)	college (1-4 or 5+)	(Give kind of willing Do NOT use	ork done during mo retired.) SSMAR	st of working	P	rinti	ing C	0.		
	17. FATHER'S NAME (First, Middle, Last). Robert Vern	on Cousins			16. MOTHER'S NA	WE (FIRE MINE) MINE	Eumame)	louck	i)		
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-4	OR DATE LEVEL N	10	entranti	1407	Eastern	Ave. Bal	timo	re, M	D 21221		
	23. PART I. Entar the diseasea, or comehock, or heart fallure. List	plicetions that caused the only one ceuse on each	e deeth. Do no ilina.	ot enter the mo	de of dying, auc	h as cerdiac or reep	iretory an	reet,	Approxima		
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¥	25. WAS CASE REFERRED TO MEDICAL			N (Check only one)	OTTOLINA	101					
Sic		OSPITAL: Inpatient XX ER/Outpatis		OTHER:	s € □ Beeldenee	6 Other (Specify)					
Ŧ	27. MANNER OF DEATH	26s. DATE OF INJURY	26b. TIME			28d. DESCRIBE NOW	NJURY OC	CURED		-	
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COMPLETED	4 Homicide determined	building, atc. (Specify)				City or Town, State		or ribrar rib	year year loon,	- 1	
7 1	29s. CERTIFIER 1 CERTIFYING PHYSICIAN	: To the beat of my knowledg	s. death occurred	at the time, data	and place, and due	to the cause(s) and me	oner ee stel	and .		\neg	
OM	one) XX MEDICAL EXAMINER: O								and menner as st	sted.	
	296. SIGNATURE AND TITLE OF CERTIFIER	11		1	29c. LICENSE NUI				Month, Day, Year)		
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임	30. NAME AND ADDRESS OF PERSON WHO CO	OMPLETED CAUSE OF DEATH	(ITEM 27) (Type	Print)	3.0.1		L . D	-C I	U , 1334		
H	THEOMOREIA				t, Bali	timore, M	larv	land	21201		
	31. DATE FILED (Month, Day, Year)	32. HEGISTMAR'S SIGNATU			-,		. K.	Land	21201		
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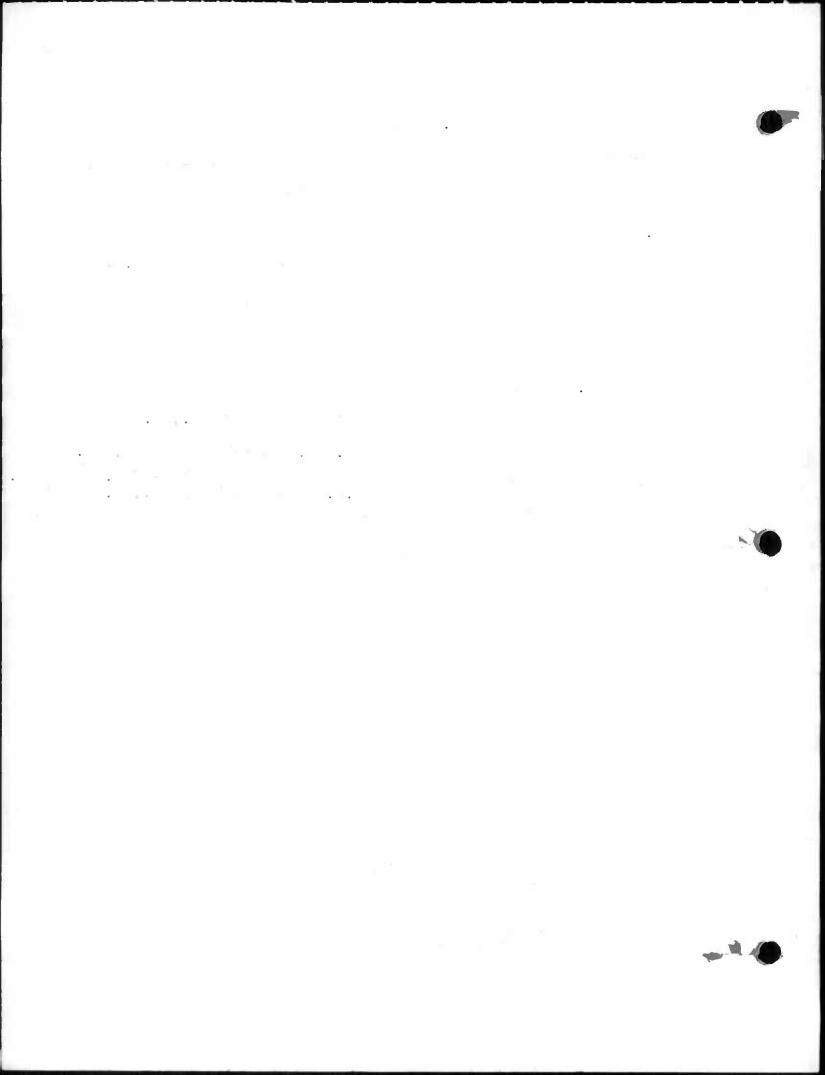
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-	On ATTINDING PHYSICIAN: The law requires that the death certificate be executed within a thurs after
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DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	10

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CEF	THEIC	AIE	IF DEAL	п	REG. NO.			
	1. DECEOENT'S NAME (First, Middle, Last) Ethel B. Covington 2. DATE OF DEATH MONTH 12 08 94 3. TIME OF OEATH									3. TIME OF OEATH	
	4. SOCIAL SECURITY NUMBER		(In yrs. last bi		UNDER 1 YEA			7. DATE OF BIRTH	DATE OF BIRTH 8. BIRTHPLACE		
	214-40-4715		90	YRS.	THS DAY	rs Hours	MIN.	05-29-0)4	Mar	yland
œ	9e. FACILITY NAME (If not institution, give :			9b.		VN OR LOCATION		ТН	9c. COUN	TY OF DE	ATH
D P	3901 Duvall Avenue Baltimore										
DIRECTO	10e. STATE 10b. COUNT	Υ	1	IOc. CITY, TO							10d. INSIDE CITY
	MD.				В	altimo	re				LIMITS?
FUNERAL	10e. STREET AND NUMBER					10f. ZIP CODE	16				HAT COUNTRY?
NE	3901 Duvall A					212				J.S.	
	1 Never Merried 2 Merried FORCES? 1 YES 2.			D	If yes	, specify Cuben,	Mexicen,	ORIGIN? (Specify Yes Puerto Ricen, atc.)	or No—		- Americen Indien, White, etc.
ВУ	3 Wildowed 4 Divorced	IP YES, GIVE WAR ON E	PAIES		,,,	YES BYENO	Specify:			Specify	Black
ETED	15. DECEOENT'S EDU (Specify anly highest grade	CATION completed)	(Give	DENT'S USU	done during	ATION most of working		16b. KIND OF BUS	INESS/INDU	ISTRY	
J.	Elementary/Secondary (0-12) College (1-4 or 5+)			life. Do NOT use retired.)				Educa	ation	1	
COMPL	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAME (First, Middle, Mele							
TO BE CC	Gustave O. Car						he Johns				
TO B	19e. INFORMANT'S NAME (Type/Print)		19b. N	IAILING ADD	DRESS (Stre	et end Number or	Rural Ro	ute Number, City or Town	n, State, Zip (Code)	7.6
F	Charles Coving	gton III	39	901 D	uva.	ll Ave	nue	Balto.,	MD.	212	16
	20a, METHOD OF OISPOSITION 1 Buriel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify)	oval from State 20	AT DUT	DATE OF DI	sposition	PK. 1	2/1	0ATE 20c. LOG 4/94 A1	butu	ity or Tow	n, State MD •
	21. SIGNATURE OF FUNERAL SERVICE LIC					ANO ADDRESS					
	22. NAME AND ADDRESS OF FACILITY 1721-27 N.Monroe ST E.L.Phillips F/H Balto., MD. 21217 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate										
ERTIFICATION	IMMEDIATE CAUSE (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST	a. Avers S OUE TO (OR AS DUE TO (OR AS DUE TO (OR AS d.	A CONSEQUE	NCE OF):	Ceo	rdiou	300	uleer 013	Cels	L	Onest and Death
IL C	PART II. Other eignificent condition	a contributing to death i	out not reeu	uiting in th	e underly	ying ceuse giv	en in Pa			24b. \	VERE AUTOPSY FINDINGS
EDICAL	Parkins		else					PERFOR			AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
ME	Demer	Nier						_ _			I TES 2 NO
AN:	DID TOBACCO USE CONT	RIBUTE TO CAUSE C			_		RTAIN				
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:	26. PLACE O	ОТ	HER:						
<u></u>	27. MANNER OF DEATH	1 Inputient 2 I ER/Out		8b. TIME OF	_	INJURY AT	_	Other (Specify)	JURY OCCL	IRED	
ВУ Р	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)		YRULMI	M 1[WORK?	_				
ED	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY building, etc. (Spe	f — At home, cify)	ferm, street	t, factory, o	ffice	2	8f. LOCATION (Street e. City or Town, State)	nd Number o	r Rural Ro	ute Number,
MPLE		ICIAN: To the best of my know									
CO	The same of the sa	R: On the besie of examination	n end/or Inve	atigation, in	my opinio	n, death occured	at the tin	ne, date end place, end	due to the	ceuse(s)	end manner es stated.
BE	29b. SIGNATURE AND TITLE OF CENTIFIED					20C. LICENS	SE NUMBI	ER 2	29d. DATE	1	Month, Day, Year)
2	30, NAME AND AGORESS OF PERSON WH	O COMPLEXED CAUSE OF DE	ATH /ITEM O	n (Since Del-	n /1	101	146		-12	1131	44
	5601 loc	h Rever	BI	cl.	"K	alto	· U	rd 21	23°)	
	DEC1 9 1994	Jagregietran's and	ATURE								



BALTIMORE, MARYLAND 21215-0020 urs after death. DIVISION OF VITAL RECORDS, P.O. BOX 68760, the death certificate be executed with

31. DATE FILED (Month, Day, Yeer)

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF GEATH 2. DATE OF DEATH MONTH 2 7. DATE OF BIRTH (Morith, Day, Year) 2-03 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR DAYS HOURS MIN 1 🗌 M 2 💢 F YRS. use as the burial-transit permit. Pages 1, 2, 3 should 9e. FACILITY NAME (if not institution, give street end number) CITY, TOWN OR LOCATION OF DEATI 9c. COUNTY OF DEATH EVIndal DIRECTOR BAITimore RESIDENCE OF DECEDENT 10e, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 2916 Edgecomb Circle Soth 21215 USA leath. Page 6 may be retained by the hospital or attending physician. funeral director, page 5 should be detached for use as the burial-tran 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cubsn, Mexicon, Puerto Rican, etc.) 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Merried 1 YES 2 NO Specify: BY Specify: 3 Widowed 4 Divorced **Black** COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compl Elementary/Secondary (0-12) College (1-4 or 5+) Private School System 6th cafeteria Worker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Scofield Crawford Minnie Caryle notified at BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Loistine Williams 2834 Rosalind Ave Balto. Md. 21215 Pe 20a. METHOD OF DISPOSITION
1 KBurlel 2 Cremation 3 Removal from State 20c. LOCATION — City or Town, Stata 20b. PLACE AND DATE OF DISPOSITION (Name of DATE must ☐ Donetion 5 ☐ Other (Specify) _ King Memorial Pk. Cem 12/22/94 Balto. Md. 21, SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY Leroy O. Dyett & Son Funeral Home, Inc. n by the freemoval. 4600 Liberty Hohts Ave. Balto. medicai Entar the disesses, or complishock, pr/heart failure. List or ations that caused the dasth. Do not anter tha mode of dying, such as cardiac or respiratory arrest, by one cause on each line. $21207\,$ in by wiy one cause on each line. Interval Between 6 completely tilled IMMEDIATE CAUSE Final Onset and Death the disease or condition cute Cardio resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) and com o burial, DUE TO (OR AS A CONSEQUENCE OF): Cardio - Vascula CERTIFICATION Sequantisity list conditions, prior to If sny, leading to immediate cause. Enter UNDERLYING attending physician ntal Hygiene prior to other 1 CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF) that initisted avants resulting in desth) LAST 0 the atten Injury, PART il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS and the AWAS ARE F PRIOR TO that shows any accident COMPLETION OF CAUSE OF DEATH? Signed Health a 1 YES 2 NO requires (In sulm dependent 1 YES 2 NO t. of PHYSICIAN: dealsits has b OR ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) Hem certificate h EXAMINER? HOSPITAL: OTHER: 1 YES 2 NO 1 Inputient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 0 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, this (Natural 5 Pending 1 YES 2 NO After ti BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Sulcide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) .09 ETED 8 Could not be DIRECTOR: / 4 Homicide 28 determined Hem 29e. CERTIFIER
(Check only one)

2 MEDICAL EXAMINER: On the basis of any knowledge, death occurred at the time, data end place, and due to the ceuse(s) end menner as attend. COMPL HOSPITAL FUNERAL E TO THE HOSPITAL
TO THE FUNERAL IDE filed within 72 h
IMPORTANT: If IT 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, deta and placa, end due to the cause(s) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 8 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year, 4490 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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Page 6 may be retained by the hospital or attending physician.

BALTIMORE, MARYLAND 21215-0020

ITEMS: 23 PART I, 27, PER MEO FILM G-719 1/9/95 t.t

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH COTTINGHAM MAMIE DEC.13, 1994 20:24 PM 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign (Month, Day, Year) 07-29-46 DAYS HOURS 242-06-0441 1 - M 2x F MIN. 48 YRS NC 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY. TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RECTOR Pages 1, 2, 3 JOHNS HOPKINS HOSPITAL BALTIMORE 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 0 MD permit. BALTIMORE 1 F YES 2 NO FUNERAL 10a STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? burial-transit 2008 BOONE STREET 21218 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, alc. 1 Never Married 2 Married s, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 2 NO BY Specify. Specify completely filled in by the funeral director, page 5 should be detached for use as the rial, cremation, or removal. 3 Widowed 4 Divorced BLACK COMPLETED 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) 9th DOMESTIC WORKER once. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at ALEXANDER COTTINGHAM MARTHA P. PONE BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 FANNIE QUEEN E. LANVALE ST. BALTO. MD. 14005 21213 be 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must 1 Surial 2 Cremation 3 Removal from State
4 Donetion 5 Other (Specify) MT. ZION CEMETERY 12-20-94 LANSDOWNE MD. examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H PA 638 N. GILMOR ST. 21217 medical 23. PART I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heert feliure. List only one ceuse on each line. Interval Retwe IMMEDIATE CAUSE (Final **Onset and Desth** the disease or condition ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE resulting in death) traumatic event, DUE TO (OR AS A CONSEQUENCE OF) signed by the attending physician and con Health and Mental Hygiene prior to bunal, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, lesding to immediate ceuse. Enter UNDERLYING other 1 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST shows any injury. PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24s. WAS AN AUTOPSY 1 VES 2 NO OF DEATH? 1 TYES 2 NO this certificate has been in with the State Dept. of DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO PHYSICIAN: UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one) item HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpallent 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 6 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked. 1 Natural 1 YES 2 NO DIRECTOR: After the hours after death v BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, fectory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 28 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the ilme, date and place, and due to the cause(s) and menner as stated. FUNERAL I = ** MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated. MPORTANT 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 黑麗 BE OCME DEC.14,1994 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARGAMOD WM111 Penn Street, Baltimore, Maryland 21201

DIVISION OF VITAL RECORDS, P.O. BOX 68760 DR

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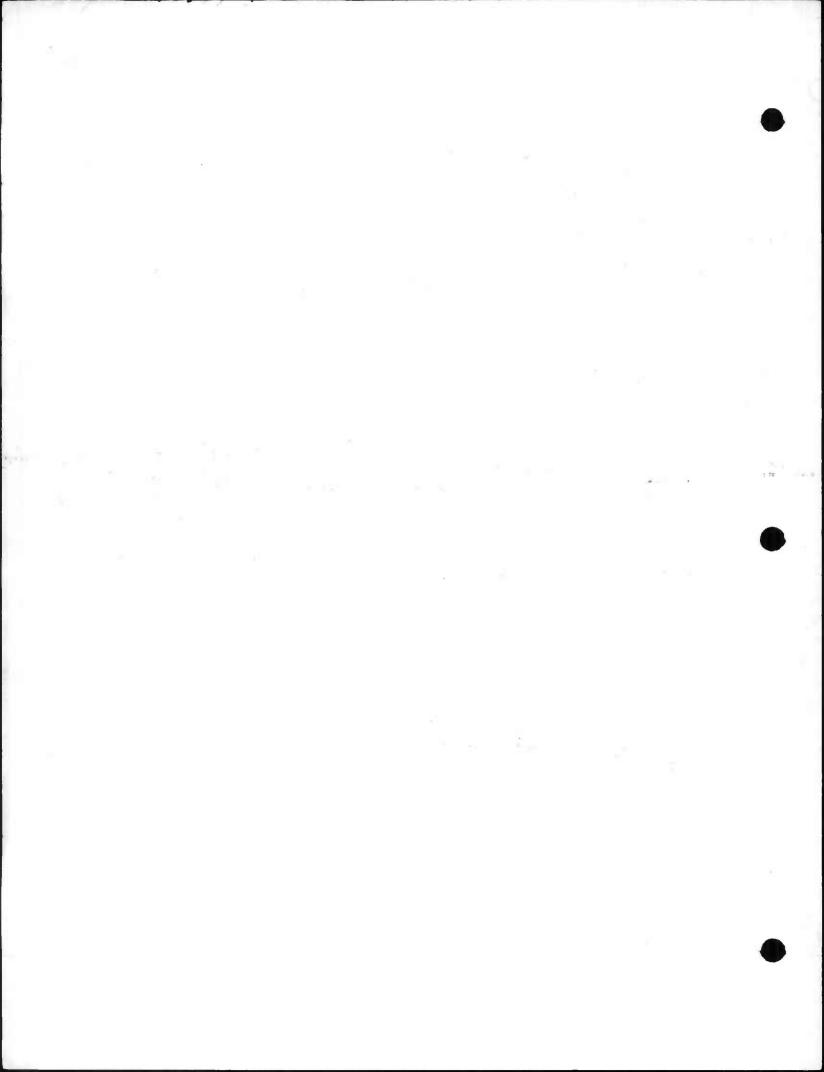
signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. has been s Dept. of H certificate h the this or After death DIRECTOR: /

REG. NO. 1. DECED 2. DATE OF DEATH 3. TIME OF DEATH 1430 4. SOCIAL SECURITY NUI 5. SEX 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign DAYS ntry) 1 X M 2 🗆 HOURS MIN 0 funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR 10a. STATE 10b. COUNTY 10c. CITY_IDWN OR LOCATION 10d. INSIDE CITY 1 VES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9 21229 hours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuben, Mexican, Puerto Rican, atc.)

1 YES 2 Specify: 14. RACE - American Indien, White, atc. 1 YES 1 Never Merried 2 Marrie FORCES? IF YES, GIVE WAR OR DATES ВУ 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) EMA 17. FATHER'S NAME (First, Middle, Lest 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ 1/101 homA 5 BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street 9 21229 pe 20a. METHOD OF DISPOSITION
1 □ Surial 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION must Donation 6 - Other (Specify) examiner 21-SIGNATURE OF FUNERAL SERVICE LICENSEE ADDRESS OF FACILITY P.A. Hame Estep FUNEVA! B105. MD 130 21217 the medical 23. PART I. Enter the diseases, Dr complications that ceused the geath. Do not enter the mode of dying, such se cardiec or reepiratory arrest, affock, or heart failure. List only one cause on each line. Approximate interval Batween IMMEDIATE CAUSE (Finel Onset and Death disease or condition resulting in death) SEVEN LEKILHERBC ADJENCUE DISEDSE WITH SETTIN DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within event, DUE TO (OR AS A CONSEQUENCE OF): or other traumatic ACUTE MYOCARDIAL INPARCTION. CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated evente resulting in deeth) LAST Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS KC. Clade PERFORMED? AMILABLE PRIOR TO shows any Diflage COMPLETION OF CAUSE 1 YES 2 NO 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL: atlent 2 DER/Outpatient 3 DOA 4 Nursing Home 5 Realdence 6 Other (Specify) 0 27. MANNER OF DEATH 28c. INJURY AT WORK? 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, 1 Natural 5 Pending 1 YES 2 NO ВУ 2 Accident 28e. PLACE OF INJURY — At home, tarm, streat, factory, offica building, atc. (Specify) 3 Sulcida 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be determined COMPLETED O THE HOSPING.
TO THE FUNERAL DIRECTOR.
To filed within 72 hours after 4 Homicide 29a, CERTIFIER 1 🗷 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE he Kon 12 12 94 un 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH



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TO THE HOGGING OF ATTROME THAT ON THE IN HOUSE that the death certificate be executed within shours after death. Page 6 may be retained by the hosp	TO THE PLINERAL DIRECTOR After the conficult has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached by the attendance of the page 5 should be detached by the page 7 should be detached by the page 7 should be detached by the page 8 should be detached by the page 8 should be detached by the page 9 should be detached by the page 9 should be detached by the page 9 should be detached by the attendance of the page 1 should be detached by the page 9 should be detached by the page 1 should be detached by the page 1 should be detached by the page 1 should be detached by the page 1 should be detached by the page 1 should be detached by the page 1 should be detached by the page 1 should be page 1 should be detached by the page 1 should be pag	IMPORTANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
thin thours aft	mation, or remo	it, the medica
e be executed wit	TO THE PLINERAL DIRECTOR After that confident has been upped by the attending physician and completely filled in by the formation of the most of the property of the formation of removal.	traumatic even
e death certifical	the attending phy Mental Hygiene	jury, or other
w mquires that th	been signed by t	shows any in
RICHAR The Isw	on ficate has	d, or item 23
T SHOP	Of Affer that me cent with	8 is marked
ISPITAL OF AT	NERAL DIRECT	NT: If Item 2
TO THE HO	TO THE FU	IMPORTA

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	FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPART	MENT OF	F HEALTH AND I	MENTAL HYGIEN REG. NO		
	t. OECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
	JAMES (CLARENCE	DAV	IS			17,199	4 08:25 PM
	050 04 5503	6. SEX 6. AGE (In yrs. I		IF UNDER 1 YEAR		7. DATE OF BIRTH (Month, Day, Year) JUN8, 1	T a	BIRTHPLACE (State or Foreign Country) CAROLINA
	9a. FACILITY NAME (If not institution, give street			9b. CITY, TOV	N OR LOCATION OF DE	ATH	9c. COUNTY	OF DEATH
CTOR	THE JOHNS HOPKINS	HOSPITAL		BALTI	MORE CITY		100	n/a
DIRECTOR	MARYLAND	n/a	10c. CITY,	BAL'	CATION TIMORE			10d. INSIDE CITY LIMITS? 1 TYES 2 NO
FUNERAL	422 N. BRADFO	ORD STREET			10f. ZIP CODE 21224	4	UNIT	OF WHAT COUNTRY? CED STATES
B⊀	11. MARITAL STATUS 1 Never Married 2 Married 2 Married 2 Married	2. WAS DECEDENT EVER IN U.S. A FORCES? 1X XYES 2 THE IF YES, GIVE WAR OR OATES NAVY	ARMED NO	If yes	DECENDENT OF HISPAN 1, specify Cuben, Mexica YES 2 NO Specify	n, Puerto Rican, etc.)	e or No 14.	RACE — American Indian, Black, White, atc. Specify: BLACK
	15. DECEDENT'S EDUCAT (Specify only highest grade co		ECEDENT'S U	SUAL OCCUP	PATION	16b. KIND OF BU	SINESS/INDUST	TRY
COMPLETED			fe. Do NOT use	retired.)	g most of working	BETHL	EHEM S	STEEL YARD
S	17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NA	ME (First, Middle, Malden	Sumame)	
BE C	CLARENCE I	DAVIS			CARI	RIE JOH	HNSON	
	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Str	eet and Number or Rural I	Route Number, City or Tow	m, State, Zip Co.	de)
2	JACQUELINE				LAFAYETTI			MORE, MD#13
	20a METHOD OF DISPOSITION FU Burial 2 Cremetion 3 Remove	of from State 20b. PLACI cametery, c	EAND DATE OF rematory or other		(Name of	1	CATION — City	
	4 Donetion 5 Other (Specify)		RISON		OREST VA	CEMETER	RY12-2	LIOWINGS MIL
	. 11 . 11	11 00						
	All V.	Holland	/	WM	. C. MAR	CH FH13	lol E.	NORTH AVE.
	23. PART I. Entar tha diseases, or con	nplications that caused the c	death. Do no	t antar tha	moda of dying, suc	h as cardlac or raap	Iratory arrest	, Approximata
	IMMEDIATE CAUSE (Final	at only one cause on each lin	18.					Onset and Death
	diagon or condition	INTRACERCERE	1 42	MORR	MAGE			12/11/94
- 1	reduiting in death)	INTRACEREBRA	EOUENCE OF)	SINORK	W IOT			160111114
z								
CERTIFICATION	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A CONS	EOUENCE OF):	:				
₹	cause. Entar UNDERLYING CAUSE (Disease or Injury							
E	that initiated eventa	DUE TO (OR AS A CONS	EOUENCE OF):					
	reaulting in death) LAST							
	PART ii. Other aignificant conditions of	contributing to death but not	regulting in	the under	vlas seves elves la	Part I. 24a, WAS AN		
₹ I	HYPERTENSION	John But Hot	readiting in	the under	ying causa given in	PERFOI	RMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
à						1 TYES 2	NO	OF DEATH?
Σ	ASPIRATION PN				~			1 TES 2 NO
AN	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL					<u> </u>		
₫ I	EXAMINER?	IOSPITAL:	ACE OF DEATH	OTHER:	one)			
PHYSICIAN: MEDICAL	1 YES 2 NO 1	Inpatient 2 ER/Outpatient			Home 5 - Realdence			
	1 Natural 5 Pending	26a. DATE OF INJURY (Month, Day, Year)	28b. TIME INJU	RY	INJURY AT WORK?	26d. DESCRIBE HOW I	NJURY OCCUR	ED
B	2 Accident Investigation	00- 81-00 05 811189			YES 2 NO			
COMPLETED	3 Suicide 8 Could not be determined	28s. PLACE OF INJURY — At I building, atc. (Specify)	iome, tarm, str	eet, factory, c	office	281. LOCATION (Street City or Town, State)		Bural Route Number,
"	29a, CERTIFIER 1 CERTIFYING PHYSICIA	N: To the heat of my beauty de-	leath see 1	at the time	data and aleas are dis-	to the exercise for		
N N		N: To the beat of my knowledge, on the beele of exemination end/or						buse(s) and manner to stated
	29b. SIGNATURE AND TITLE OF CERTIFIER			,				
BE	Paola Dovato MC) Characa and III	1 1		29c. LICENSE NUN		29d. DATE SI	GNED (Month, Day, Year)
2	30. NAME AND ADDRESS OF PERSON WHO C	(house staff	-)		M557	6	12	117194

21287

mo

500 N, WOLFE

31. DATE FILED (Month, Day, Year)
DEC1 9 1984

Packs Dorato MD (Nouse STAff)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (FEM 27) (Type, Print)

STREET

BALTIMORE

the function of the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.

contact of item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 in

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

FOR 1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPARTN CERTIFIC			MENTAL HYGIEN		
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH		3. TIME OF DEATH
Sylvia Leeanr	na Davis				Dec. 18,	1994	10:44 P. M
4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIR	THPLACE (State or Foreign
219 20 1158 9a. FACILITY NAME (# not institution, give	1 M 2 K F 68	YRS.	OCITY TOWN C	HOURS MIN.	Aug. 24	1926	Md.
3431 Abbie Place					-Ain		
RESIDENCE OF DECEDENT	<u> </u>		Baltimo	re		Baltim	ore
10a. STATE 10b. COUNT		10c. CITY, T	OWN OR LOCAT	ION			10d. INSIDE CITY LIMITS?
Baltı	more		Balti	more			1 TES 2 NO
10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
3431 Abbie Plac				21244		U.S	. A .
11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER II FORCES? 1 YES		13. WAS DEC	ENDENT OF HISPAN	IIC ORIGIN? (Specify Yen, Puarto Rican, etc.)	or No- 14, RA	CE — American Indian, ek, White, atc.
3 Nidowed 4 Divorced	IF YES, GIVE WAR OR D	ATES		2 NO Specify			oolfy:
15. DECEDENT'S EDU	UCATION	16a. DECEDENT'S USU	UAL OCCUPATIO	DN .	165 KIND OF BU	SINESS/INDUSTRY	ite
(Specify only highest grade	completed) College (1-4 or 5+)	(Give kind of work life. Do NOT use re	done during mo	st of working	TOO. KIND OF BO	314E33/14D03 1 HT	
7	= Conege (I= Of 5+)	Cashier			Pant	ry Pride	9
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maiden		
John William Shif	flett			Shir	ley Koonta	2	
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING AD	DRESS (Street a	nd Number or Rural F	Poute Number, City or Tow	n, State, Zip Code)	
Franklin D. Ship	ley	3635 R	lockda1	e Terrac	e Baltimor	e, Md.	21244
20a. METHOD OF DISPOSITION 1 Description 2 Cremation 3 Rem		PLACE AND DATE OF D	ISPOSITION (Na			CATION — City or	
4 Donation 5 Other (Specify)		etery, cremetory or other, Lake View	Mem. P	ark Dec	. 22. 1994	Sykesy	ille Md
21. SIGNATURE OF FUNERAL SERVICE LI	CENSEE		22. NAME AN	ID ADDRESS OF FAC	CILITY		
> TAMMY YI)	Hount		P.O. B.	ov 195 s	Haight Fur ykesville,	Md 21	ne 70/
23. PART I. Enter the diseases, or	complications that caused	the deeth. Do not	enter the mo	de of dving, suci	h as cardiec or reen	iratory arrest	Approximate
shock, of heart failure.	List only one cause on e	ech line.					interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition	Thi	thatach	Marc	mm	han 18	1	Onset and Desth
reculting in death)	DUE TO (OR AS A	CONSEQUENCE OF):	.0 /	1	Jam Va	VAL	<u></u>
			Ju	una uy, les	re		
Sequentially list conditions, if any, leeding to immediate	DUE TO (OR AS A	CONSEQUENCE OF):					
cause. Enter UNDERLYING CAUSE (Disease or injury	c						
that initiated events	DUE TO (OR AS A	CONSEQUENCE OF):					
resulting in death) LAST	d						
PART ii. Other eignificant condition	ns contributing to death b	ut not reculting in ti	he underlying	ceuee given in	Pert i. 24a. WAS AN	ALITOPSY 24	b. WERE AUTOPSY FINDINGS
	-				PERFOR	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE
					1 🗆 YES 2	HAMO	OF DEATH?
DID TOBACCO USE CONT	DIRLITE TO CALISE O	E DEATH VEC	ПИОГ	UNCERTAIL	76		1 TYES 2 NO
25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEATH (ONCERIAI	х ⊔		
EXAMINER?	HOSPITAL: 1 Inpetlant 2 ER/Outp		THER:	5 Masidence	B C Other (Specific)		
27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME OF	F 28c, INJI	JRY AT	28d. DESCRIBE HOW I	NJURY OCCURED	
1 Natural 5 Pending	(Month, Day, Year)	INJURY		RK? ES 2 NO			
2 Accident Investigation 3 Suicida 8 Could not be	28a. PLACE OF INJURY building, atc. (Spec	— At home, farm, strea	it, factory, office		281. LOCATION (Street	and Number or Rural	Floute Number,
4 Homicide detarmined	bunuing, atc. (Spec	ny)			City or Town, State)		
29a. CERTIFIER CERTIFYING PHYS		edge, death occurred at	t the time. date	and place, and does	to the cause(a) and ma-	mer se stated	
CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and menner as stated. MEDIC AND ER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(a) and manner as stated.							
			n my opinion, de	eath occured at the	time, data and place, an	d due to the cause	(a) and manner as stated.
	ER: On the basis of examination		n my opinion, de				
one) 2 MEDICAL TXA	ER: On the basis of examination		n my opinion, de	29c, LICENSE NUM			(a) and manner as stated, (b) (Month, Day, Year)
29h. BIGNATURE AND TITLE OF CONTROL	ER: On the basis of examination	and/or investigation, in					
one) 2 MEDICAL TXA	ER: On the basis of examination	and/or investigation, in					
29h. BIGNATURE AND TITLE OF CONTROL	ER: On the basis of examination	ATH (ITEM 27) (Type, Prin					

- marchaellain 255 3 g

2 X MEDICAL EXAMINER: On the

RESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111 Penn

TURE AND TITLE OF CERTIFIER

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760

use as the burial-transit hours after death. Page 6 may be retained by the hospital or attending physician jo signed by the attending physician and completely filled in by the funeral director, page 5 should be detached Health and Mental Hygiene prior to burial, cremation, or removal. To notified pe must examiner medical the event. other traumatic this certificate has been a with the State Dept. of HOSPITAL OR ATTENDING PHYSICIAN: The law 23 50 marked. DIRECTOR: After the hours after death vitem 28 Is mark IMPORTANT: IF

within

should

Pages 1, 2, 3

permit.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DEC. 85 5:32P JOHN DANTZLER 4 SOCIAL SECURITY NUMBER 5. SEX 8. AGE (in yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 250-22-8161 1 🔀 😾 2 🗌 F YAS. 69 N.C. 1-1-25 99. FACILITY NAME (If not institution, give street and number)
851 GEORGE STREET APT. 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY 9c. COUNTY OF DEATH DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Baltimore X YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 851 George St. Apt. 9C 21201 USA 11. MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 THE IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yee, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried Specify: Black 1 TES 2 NO Specify. BY 3 Widowed 4 Divorced 0 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL Carpenter 17. FATHER'S NAME (First Middle Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary MArshall 1518 N. Aisquith St Balto. MD 21228 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State metery, cremetory or other Mt. Ziion Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
James A. Morton & Sons Funeral Homes 1701 Laurens St. 23. PART LEtter the diseases, or complications that ceuced the deeth. Do not enter the mode of dying, such as cerdiac or respiratory street, mock, or heart failure. List only one cause on each line. Approximate intervsi Between IMMEDIATE CAUSE (Finei Onset and Death diseese or condition resulting in death) CERTIFICATION Sequentially liet conditions, DUE TO (DR AS A CONSEQUENCE OF) If sny, lesding to immediate cause. Enter UNDERLYING CAUSE (Diseese Dr injury DUE TO (OR AS A CONSEQUENCE DF) thet initieted events recuiting in death) LAST PART II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY YES 2 NO OF DEATH? YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL OTHER: 1X YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 | Nursing Home X XResidence 6 Other (Specify) 27. MANNER OF DEATH 28b. TIME OF 20c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural Pending Investigation BY 2 Accident 28e. PLACE OF INJURY — At home, farm, building, atc. (Specify) 3 Suicide street, fectory, office 281 LOCATION 6 Could not be COMPLETED Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, end due to the ceuse(s) end menner

ition end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) end manner as stated,

111 Penn Street, Baltimore, Maryland 21201

29c. LICENSE NUMBER

O.C.M.E.

OHMH-16 Rev 1/89

06/94

29d. DATE SIGNED (Month, Day, Year,

DEC.

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG NO.

		REG. NO.	
		1. DECEDENT'S NAME (First, Middle Last) 2. DATE OF DEATH MONTH DAY QUEAR 3. TIME OF DEATH MONTH DAY QUEAR	H P M
-		4. SOCIAL SECURITY NUMBER 215-03-3436 5. SEX 6. AGE (In yrs. last birthday) 1 M 2 F 81 7. DATE OF BIRTH (Month, Day, Year) 1 M N 2 F 81 7. DATE OF BIRTH (Month, Day, Year) 1 M N 2 F 81 7. DATE OF BIRTH (Month, Day, Year) 1 M Aryland	reign
should		9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH	
2, 3	DIRECTOR	Sinai Hospital Baltimore Baltimore City	
Segi	H H	10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS?	
.≝ 2	5	Maryland Baltimore City Baltimore	NO
E. ed	IAL	10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?	
n. ansit	삘	5248 St Charles Avenue 21215 U.S.A.	
YLAND 21215-0020 by the hospital or attending physician. be detached for use as the burial-transit permit. Pages 1, at once.	BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 2 Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Yes 2 NO If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 Yes 2 No Specify: White	n,
r attendi	8	15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY	
212 al or a for us	COMPLETED	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use refired.) (Give kind of work done during most of working life. Do NOT use refired.)	
D Spita	鱼	10th Plumber Steamfitter Goddard Space Flight Ce	nter
YLAND by the hospit be detached at once.	ŏ.	17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname)	
Y Y	BE	Joseph A. Derreth Emma Sauers	
MARYLAND retained by the hospit 5 should be detached notified at once.	9 0	19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
0) 4	۲	Mrs. Theresa Derreth 5248 St Charles Ave. Balto. Maryland 21215	
IMORE, Page 6 may be al director, page		20a. METHOD OF DISPOSITION 1 1	
MOR ge 6 may rector, p		Lorraine Park Cemetery 12/20 Woodlawn, Maryland	
BALTIMORE, ser death. Page 6 may be the funeral director, page rai.		21. NAME AND ADDRESS OF FACILITY	
BALT after death. by the funeramoval.		Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21	122
c a		23. PART I. Entar the diseases, or compilications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory screet.	133
or red		shock, or heart fallura. List only one cause on each line.	tween
ation,		disease or condition KE PINATTA W TOLLING	21
WT60. ured with cours completely filled in brida, cremation, or reference cevent, the medi		resulting in death) s. Due To (or as a consequence of):	-
RDS, P.O. BOX 68760, at the death certificate be executed with by the attending physician and complete and Mental Hygiene prior to burial, cren y injury, or other traumatic event	z	COYD	2
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BOX cate be ex hysician a prior to	S	CAUSE (Disease or Injury C.	
S, P.O. B(death certificate attending physic ental Hygiene printy, or other tr	쁘	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST	
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ORDS, that the dealed by the att the and Menta any injury,		PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FIN	IDINGS
ORI that t ed by h and	EDICAL	Y COSTOSTO A PERFORMED? AMAILABLE PRINCE OF A COMPANY OF	
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REC v requires been sign t. of Heali	Σ.	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN	۱
F VITAL RECC SICIAN: The law requires certificate has been sign to the State Dept. of Healt i, or item 23 shows	SICIAN:	25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)	
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OF V HYSICIA his certif with the	₹	27. MANNER OF DEATH 288. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED	\neg
NG PHYS tter this ceath with marked,	ВУ Р	1 Netural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO	- 1
ON WOING F	0 8	3 Suicide 8 Could not be 26e. PLACE OF INJURY — At home, ferm, street, fectory, office 281, LOCATION (Street and Number or Rural Route Number,	\neg
2 af a st 82	III I	4 Homicide datarmined City or Town, State)	- 1
OR OR Hour	빌	29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.	
₹ ¥ k =	COMPLET	(Check only one) 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(a) and manner as stated. MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, data and place, end dua to the cause(a) and menner as stated.	sted.
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TO THE HOSP! TO THE FUNER be filed within	B	29d. LICENSE NUMBER 29d. DATE SIGNED (Mogifi, Day, Year) ↑ 12 17 194	
, E E 2 €	임	30. MATTIE AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) TIPOS. Print)	=
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		31. DATE FILED (Month, Day, Year) DEC1 9 1994 July Standard Residual Control of the Standard Resi	
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DIVISION OF VITAL RECORDS, P.O. BOX 6876	HOSPH	FUNE	Mills	CANT
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	TO THE HOSPITAL OR ATTENDING PHYSICAN: The law inquires that the death certificate be executed a	TO THE RUNERAL DIRECTOR After this certificate has been signed by the attending physician and com-	2	IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other trasmatic ev

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 1 TIME OF DEATH WILLIAM 12 ILL. 4. SOCIAL SECURITY NUMBER 6. AGE (in you last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH B. BIRTHPLACE (State or Foreig DAYS HOURS 1 X M 2 | F JAN 31, 218-26-4881 64 YRS. 1930 MARYLAND 9s. FACILITY NAME (If not institution, give street and number) SO, CITY, TOWN OR LOCATION OF DEATH IK. COUNTY OF DEATH DIRECTOR LAUREL REGIONAL HOSPITAL PRINCE GEORGE LAUREL RESIDENCE OF DECEDENT 10e STATE 10h, COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND PRINCE GEORGE LAUREL 1 VEB 2X NO FUNERAL 10s STREET AND MUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 9586 MUIRKIRK ROAD APT. T-2 20708 USA WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)
 I YES 2 NO Specify 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Y YES 2 NO IF YES, GIVE WAT OR DATES 11. MARITAL STATUS 14. RACE -- American Indian, Black, White, etc. 1 Never Married 2 X Married BY Specify: WHITE 3 Widowed 4 Divorced 6/51 - 10/52 COMPLETED IS. DECEDENT'S EDUCATION His. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during must of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (I-4 or 5.4) 12 TEACHER PUBLIC SCHOOL 17. FATHER'S NAME (First, Miciple, Last) 18. MOTHER'S NAME (First, Allordie, Maiden Surrent HARRY J. ELLIS ELIZABETH A. EVERT BE 19s. INFORMANT'S NAME (Spe/Frint 196. MAILING ADDRESS (Sitner and Number or Rural Route Number, City or Town, State, Zip Code, 2 ELEANOR SUE ELLIS 9586 MUIRKIRK ROAD APT T-2, LAUREL, MD 20708 20s. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Warmers) DATE 20s. LOCATION - City or Town, State 20s. METHOD OF DISPOSITION
1 □ Burial 2 □ Cramation 3 □ 6
4 □ Donation 5 □ Other (Specify) _ BALTIMORE WASHINGTON CREM 12/16 LAUREL, MARYLAND 21. SIGNATURE OF FUNDANT SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MD 20707 23. PARTA, Enter the diseases, or co the daused me death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List phly Interval Between IMMEDIATE CAUSE (Final Onset and Death mma mnigt disease or condition resulting in death) CONSBRUTSCUM BUCCIDEM CERTIFICATION Sequentially list conditions, TO TOM U & CLONUS IS if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF GAUSE 24s. WAS AN AUTOPSY MEDICAL Y TYES 2 P HO OF DEATH? 1 YES 2 NO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL

38. PLACE OF DEATH (Check only one

HOSPITAL OTHER: T YES I NO 1 C Inpetient 2 ER/Outpetient 3 DOA 27, MANNER OF DEATH 28s. DATE OF INJURY 286. TIME OF INJURY

1 Netural 5 Pending Investigation 2 Accident

3 Suinide 6 Could not be 4 | Homicide

(Check only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28c. INJURY AT WORK?

1 YES 2 NO

ng Home S 🖸 Residence 8 🖾 Other (Specify)

29c. LICENSE NUMBER

264. DESCRIBE HOW INJURY OCCURED

28f. LOCATION (Street and Number of Rural Routs Number City or Toers, Street

29d. DATE SIGNED (Month, Day, Year)

12-14

2 MEDICAL EXAMINER: On the on and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated

PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

do recistrairs sicharine. FILED (Mont) 9

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Spocify)

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DIVISION OF VITAL RECORDS THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 fours after death. Page 6 may be retained by the hospital or attentions proyecum.

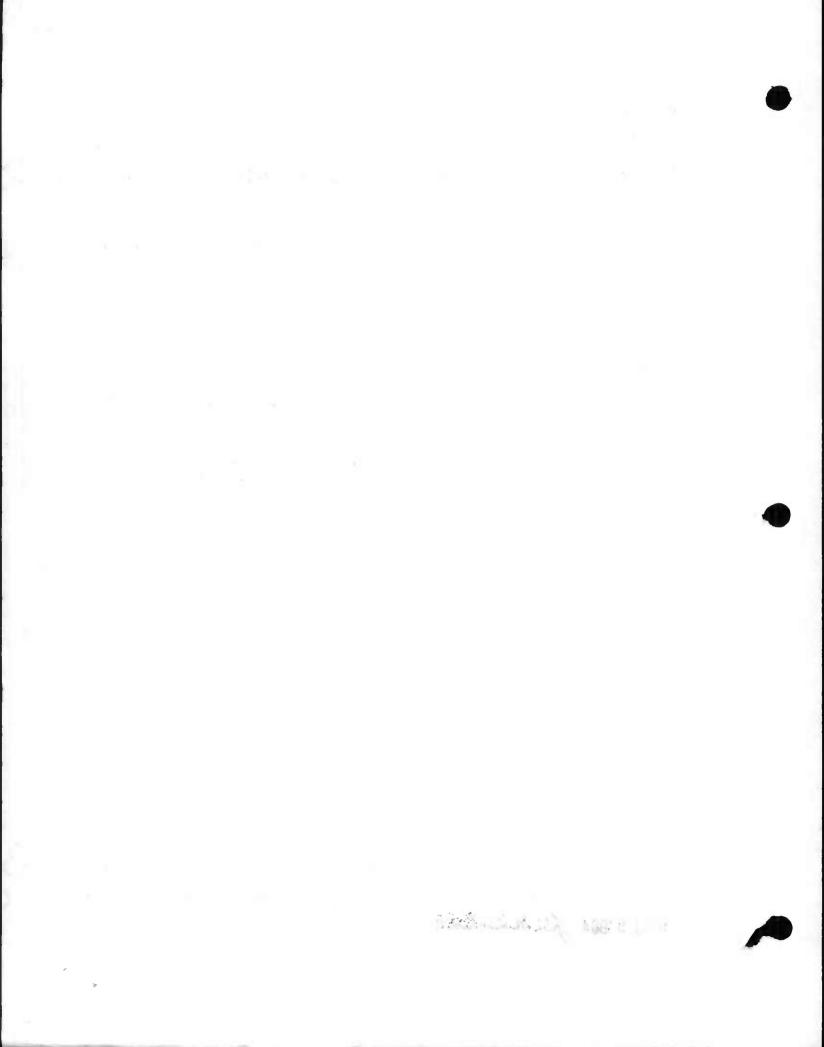
TO THE FUNERAL DIRECTOR: After this certificate has been sligned by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

	STATE OF MARYLAN				MENTAL	HYGIENE	
		CERTIFICATE	OF DEAT	ГН		REG. NO.	
irst, Middle, Last)	0				2. DATE O	E DEATH	_

	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGIE!			
	1. DECEDENT'S NAME (First, Middle, Last)	Q		0,112 01	DEATT	2. DATE OF DEATH	·	3. TIME OF DEA	TM
	Relanho	E. (n	morra	h.			AY YEA	7:30	
į	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		RTHPLACE (State or F	iomico
	220-24-3195	1 M 2 F	O 1 YRS.	MONTHS DAYS	HOURS MIN.	(Month, Day, Year) 8/17/0	Co	untry)	
	9e. FACILITY NAME (If not institution, give a	street and number)	91	9b. CITY, TOWN (R LOCATION OF OR		9c, COUNTY O	alto., Ma	Lylan
DIRECTOR	TRINITY GREI	iAtric Cen	ter	2 11 -	ore, n	10		Limone	
3EC	10a. STATE 10b. COUNT	Y	10c, CITY,	TOWN OR LOCAT	ION			10d. INSIDE CIT	Y
	Maryland Ba	ltimore	Ва	alt i more				1 YES 2 K	NO
AL	10e. STREET AND NUMBER			101	ZIP CODE		10g. CITIZEN C	F WHAT COUNTRY?	
FUNERAL	7600 Clays Lane				21	207	U.S	S.A.	
5	11. MARITAL STATUS	12. WAS DECEDENT EVER		13. WAS DEC	ENGENT OF HISPAN	IIC ORIGIN? (Specify Ye	a or No- 14, R	ACE — American Ind	ien.
	1 Never Married 2 Married	FORCES? 1 YES		If yes, spo	city Cuban, Maxica	n, Puerto Rican, etc.)	В	leck, White, etc. pecify:	
8√	3 🙀 Widowed 4 🗌 Divorced				X		"	White	
COMPLETED	15. OECEDENT'S EDU (Specify only highest grade	CATION completed)	16a. DECEDENT'S L	ork done during mo	N at of working	16b. KIND OF BU	ISINESS/INOUSTR	Υ	
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use	retired.)	n or working				
MP	6th		Housewi	fe					
8	17. FATHER'S NAME (First, Middle, Last)					ME (First, Middle, Maider	Sumame)		
BE	William Buckhe	it			Emilea	Parrish			- 1
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street a	nd Number or Rural I	Route Number, City or Tox	vn, State, Zip Code)		
۱ ۲	Mildred Speargas		4270 (Clydesda	le Ave.,	Balto. M	aryland	21211	
	20a. METHOD OF DISPOSITION fy□ Burlal 2 □ Cremation 3 □ Ram	20t	PLACE AND DATE OF	DISPOSITION (Ne	ne of	OATE 20c. LC	CATION — City or	Town, State	
	4 Donation 5 Other (Specify)	I	ouden Par	k Cemet	ery 12/	19/94 Ba	ltimore,	Marylan	d
	21. SIGNATURE OF FUNERAL SERVICE LIC	CENSEE	1	22. NAME AN	D ADDRESS OF FA	CILITY	wal Wome		
	· M Ma	~ 10:7	1/2			Jr. Fune ve., Balt			2121
	23. PART i. Enter the diseeses, or o	complications that cause	t the death. Do no	d enter the mo	to of duing and	ve., ball	Inore, r		
	snock, or neart failura.	List only one cause on e	ach line.	c arrest the mo	a or aying, suc	i as cardiac or resp	matory arrest,	Approxim interval E	atween
	iMMEDIATE CAUSE (Fine)	Car	100					Onset an	d Death
İ	resulting in death)	- 29%	CONSEQUENCE OF	7 .				1	NC
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₫	Sequentially list conditions,	b. DUE TO (OR AS /	CONSEQUENCE		~	0		<10	2(
ERTIFICATION	If any, leading to immediate ceuse. Enter UNDERLYING	1		Luka.	Ones	nt Con	~1	1	0.
띮	CAUSE (Disease or injury that initiated events	DUE TO (OR AS /	CONSEQUENCE OF	0		1		(10	147
	resulting in death) LAST	(K	No. A	- Proli		1 7	46
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AL	PART II. Other significent condition	e contribution to death b	ut not resulting in	the underlying	ceuse given in	Part i. 24a. WAS AN PERFO		24b. WERE AUTOPSY F	-
MEDIC	Mon	VIllet	86 M	sear		1 YES		COMPLETION OF	
							77	OF DEATH?	NO.
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PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?			28. PL	ACE OF DEATH (Che	ack only one)			
is	1 TES 2 THE	HOSPITAL: 1 Inpatient 2 ER/Outp		OTHER:	5 Residence	8 Other (Specify)			
Ì	27. MANNER OF DEATH	28a. OATE OF INJURY	26b. TIME	OF 28c. INJI	IRY AT	28d. DESCRIBE HOW	NJURY OCCURED		
B	1 Natural 5 Pending	(Month, Day, Year)	INJU		RK? ES 2 NO				
	2 Accident Investigation 3 Suicide 8 Could not be	28a. PLACE OF INJURY	- At home, farm, str	eet, factory, office		28f. LOCATION (Street	and Number or Run	al Route Number.	$\overline{}$
	4 Homicide detarmined	building, etc. (Spec	ary)			City or Town, State			
ן ב	29a. CERTIFIER CERTIFYING PHYSI	CIAN: To the best of my know	ledge death convert	of the time date	and alone and d		Lateramina		
COMPLETED	(Check only one) 2 MEDICAL EXAMINE	R: On the beels of examination	n and/or Investigation	in my opinion 4	eth occured at the	to the cause(s) and ma	nner ee stated.	a(a) and man	
	296. SIGNATURE AND TITLE OF CERTIFIER			,					rated.
W	THE OF CERTIFIER	11	11	1000	29c. LICENSE NUM	M S (G	29d. DATE SIGN	150 (Month, Gay Near)	
2	30. NAME AND ADDRESS OF PERSON/WHO	O COMPLETE CAPET OF OF	ATM OTEM A	yaran	17	1767	-14	16144	
	Montrell	no Di RI	byeno	5 U	NIA	Bo Claire 1	Rd E	3mbh	
	DECT 9 1894	32 HEGISTRAR'S SIGN	ATURE				- M (
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be detached for use as the burial-transit permit. Pages 1, 2, 3 should nours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ar nours after death. Page 6 may be retained by the host	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache		IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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	2	2	be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.	₹

B.K.S						94	3740
FOR 1 - STATE REGISTRAR	STATE OF I	MARYLAND / OEPAR Certif	RTMENT OF	HEALTH AND	MENTAL HYGIEN REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)	-				2. DATE OF DEATH		3. TIME OF E
CHARLES		FERGUSON			DEC. 13	94	0859
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		HPLACE (State of
218-44-2466	1 5 M 2 🗆 F	47 YRS.	MONTHS DAYS	HOURS MIN.	11714719	47 Ba	ito.,
Se. FACILITY NAME (If not institution, give s	treet end number)		9b. CITY, TOWN	DR LOCATION OF D	EATH	9c. COUNTY OF	OFATH

	CHARLES		FERGUS	SON				DEC. 1	5 9	VEAR	1859 A _M	
	4. SOCIAL SECURITY NUMBER 218-44-2466	5. SEX	6. AGE (In yrs. less		IF UNDER 1 YEAR		24 HRS. MIN.	7. DATE OF BIRTH (Month, Day, Year) 11/14/19	147	8. BIRTHPL/ Country)	O • , MD	
	9e. FACILITY NAME (If not institution, give s	47	Tho.	9h. CITY TOW	N DR LOCATIO	N OF DE			Balt Balt			
DIRECTOR		GOOD SAMARITAN HOSPITAL E					E C		J. COOK	- OF OEAT		
REC	10e. STATE 10b. COUNTY	1			TOWN OR LO					10	d. INSIDE CITY LIMITS?	
	Maryland 100. STREET AND NUMBER			В	altim						YES 2 NO	
FUNERAL	1437 Limit Ave				101. ZIP CODE 21	239		10g. CITIZEN OF WHAT COUNTRY?				
B	11. MARITAL STATUS 1 Never Merried 2 K Merried 3 Widowed 4 Divorced		TEVER IN U.S. ARI XYES 2 N ABOR DATES 7	10	If yes,	epecify Cuber ES 2 ND	, Mexicer	IIC ORIGIN? (Specify Yen, Puerto Rican, atc.)	es or No—	I4. RACE — Black, W Specify:	American Indian, hite, etc. Black	
	15. OECEDENT'S EDU (Specify only highest grade	CATION completed)	(Gr	ve kind of w	JSUAL OCCUP	TION most of working	9	16b. KIND OF BU	JSINESS/INDU	STRY		
COMPLETED	Elementery/Secondary (0-12) 12th	College (1-4 or 5+) life.	Do NOT use	ver			Yello	ow Ca	b		
BE CO	17. FATHER'S NAME (First, Middle, Last) Charles Ferg	uson			-		ER'S NAI	ME (First, Middle, Maider an	Surneme)			
10	190. INFORMANT'S NAME (Type/Print) Valerie Fergus	on	198	1437	Limi	t Ave	or Rural R	Balto	vn, State, Zip C	21	239	
	20e. METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Rem. 4 Donation \$ Other (Specify)	oval from State	20b. PLACE A cometery, cres	IND DATE OF	F DISPOSITION	Name of 1	2/2 t.	Cem. Ow:	nas	ity or Town,	State MD	
	21. SIGNATURI OF FUNERAL SERVICE LIC	ENSEE	Just	+	LERC	Y O.	DYE	TT & SOI	V FUN	ERAL		
	23. PART I. Enter the diseepes Dr	23. PART I. Eater the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										
	IMMEDIATE CAUSE (Finel disease Dr condition resulting in deeth) Due TO (OR AS A CONSEQUENCE OF):											
NO	Sequentially list conditions, b.											
MEDICAL CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury											
ERTI	that Initiated events resulting in deeth) LAST d											
AL C	PART il. Other algnificent condition	s contributing to	death but not re	eaulting in	the underly	ing ceuse g	lven in I	Part i. 24a. WAS AF			RE AUTOPSY FINDINGS	
EDIC									CD DF	MILABLE PRIOR TO MPLETION OF CAUSE DEATH?		
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									YES 2 NO		
PHYSICIAN	25. WIS CASE REFERRED TO MEDICAL 26. PLACE DF DEATH (Check only one)											
YSI	1 X YES 2 □ NO	1 ☐ Inpatient X□			OTHER: 4 - Nursing H	ome 5 🗆 Res	Idence	8 Other (Specify)				
ву рн	27. MANNER OF OEATH 28e. DATE OF INJURY (Month, Day, Year) 2 (Accident Investigation				RY	NJURY AT WORK? YES 2	ND	28d. DEŞCRIBE HOW	INJURY OCCU	RED		
	2 Accident 3 Suicide 8 Could not be determined 4 Homicide City or Town, Street 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, ferm, atreet, fectory, office City or Town, Steete								Number,			
COMPLET	29e. CERTIFIER (Check only one) CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner se stated.											
	29b. SIGNATURE AND TITLE OF CERTIFIER		amination end/or in	nvestigation	, in my opinior							
TO BE	Theodor 1	le Kini	of ru	Co		O . (C.M.				6, 1994	
	30. NAME AND ADDRESS OF BERSON WHI THE DOORE M		111	Penr	n Str	eet,	Balt	timore,	Maryl	and	21201	
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Charles Pergusun

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19/20 Darking Corect Vol. Con. Crings Fills, "I

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No Charlest W. pogia i

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within completely filled in by the funeral director, page 5 may be retained by the hard bean signed by the attention physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR	CERTIF	ICATE OF DEATH	REG. N	0.					
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH			3. TIME OF DEATH			
	GUST FARSADAKIS			MONTH 12	DAY 17	94	4:40 4			
1		E (In yrs. lest birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH		-	IPLACE (State or Foreign			
	577-72-8271 1⊠M2□F	75 vas.	MONTHS DAYS HOURS MIN.	(Morth, Day, Year) 6-6-19		Count	ny) eece			
	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH									
DIRECTOR	Johns Hopkins - Bayview Hos	pital	Baltimore City	r						
15	RESIDENCE OF DECEDENT									
2	10a, STATE 10b, COUNTY		Y, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
	Maryland -	Bal	timore				YES 2 NO			
A	10e. STREET AND NUMBER		101. ZIP CODE				WHAT COUNTRY?			
FUNERAL	422 S. Newkirk Street		21224		U.S	5.A.				
3	11. MARITAL STATUS 12. WAS DECEDENT EVE		13. WAS DECENDENT OF HISPA	NIC ORIGIN? (Specify Y	es or No-	14. RACE	E — American Indian,			
	1 Never Married 2 Married FORCES? 1 YE		If yes, specify Cuban, Maxic 1 YES 2 NO Speci	an, Puarlo Rican, etc.)		Bleci	k, White, atc.			
B	3 Widowed 4 Divorced		1 120 220 110 0,000	·y.		Speci	"" White			
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	18a. DECEDENT'S	USUAL OCCUPATION	18b. KIND OF B	USINESS/INC	DUSTRY				
1 12	Elementary/Secondary (0-12) College (1-4 or 5+)	life. Do NOT us	work done during most of working ie retired.)							
틸	12th	Mechai	nic	Autom	obile					
ŏ	17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NA	AME (First, Middle, Maide	n Surname)					
E C	Dimitrios Farsadakis			Lagoudak						
00	19s. INFORMANT'S NAME (Type/Print)	19b. MAILING	ADDRESS (Street and Number or Rural			Code				
2	Dimitrios Farsadakis		. Newkirk Street				1224			
	1 ☑-Buriet 2 ☐ Cremetion 3 ☐ Removal from State	emetery, cremetory or o	OF DISPOSITION (Name of their place)	1	OCATION —					
	4 Donation 5 Other (Specify) 21. SIGNATURE ## FUNERAL SERVICE LICENSEE	Anastasis		12-21 Pi	reaus	, Gre	ece			
		,	Matthews Fur							
	I Con S. matthe	w	3021 Eastern		1+: mol	ro A	14 2322/1			
	23. PART i. Enter the diseases, or complications that cause	sed the deeth. Do r	not enter the mode of dving, aug	ch as cerdiec or rea	Diretory an	rest.	Approximate			
	shock, or heert fallure. List only one cause on	each lina.		EFAR 8	,	1100	interval Between			
	IMMEDIATE CAUSE (Final disease or condition	/	00 0 0 1				Onset and Death			
	disease or condition resulting in death) s. HYPOXIA / HYPO TENSION DUE TO (OR AS A CONSEQUENCE OF):									
o	Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
CERTIFICATION	cause. Enter UNDERLYING TRACHEAL / / UNIC MASS RILL 9 mg									
윤	CAUSE (Diseese or injury that initieted events	S A CONSEQUENCE OF	THE FIRSS,	NUL			170			
Ē	resulting in deeth) LAST	CELL	CANCER OF	THE 11	NC		II Mo.			
S	d. 31-11122	CLLL	CHNCUR OF	THE LO	140		11710.			
	PART ii. Other significant conditions contributing to deeth				N AUTOPSY	24b.	WERE AUTOPSY FINDINGS			
DICAL	SUPERIOR VENACAVA SYA	JOROME.	NEUTROPE NIC	HX. I YES	DAMED?	-	AVAILABLE PRIOR TO COMPLETION OF CAUSE			
MED		,			2 (2) 110		OF DEATH?			
2	DID TOBACCO USE CONTRIBUTE TO CAUSE	OF DEATH VE	S TANO III LINCERTAL				1 TYES 2 HO			
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	28. PLACE OF DEAT		N LI						
<u>□</u>	EXAMINER? HOSPITAL:		OTHER:	1117777						
148	1 ☐ YES 2 ☐ NO 1 ☐ Pringetient 2 ☐ ER/O 27. MANNER OF DEATH 28s. DATE OF INJUR		4 Nursing Home 5 Residence							
	1 Natural 5 Pending (Month, Day, Year		URY WORK?	28d. DEŞCRIBE HOW	INJURY OC	CURED				
BY	2 Accident Investigation		M 1 YES 2 NO							
	3 Suicide 6 Could not be building, atc. (S)	RY — At home, term, a pecify)	treet, factory, offica	281. LOCATION (Street City or Town, State	t and Number s)	or Rural R	loute Number,			
	4 Hollings Garantings									
COMPLETED	29a. CERTIFER (Check only 1 CERTIFYING PHYSICIAN: To the beat of my kin	owledge, dasth occurre	ed at the time, data and place, and due	to the cause(s) and m	anner aa staf	led.				
S	one) 2 MEDICAL EXAMINER: On the basis of examina) and manner as stated.			
	195 MONATURE ANOTITLE OF CERTIFIER		29c. LICENSE NU		-		(Month, Day, Year)			
H	VM II CALL N	1/)	95010		. /	2				
임	39 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	DEATH (ITEM AT) (7			I	KCLA	ber 17, 1994			
[]	MARKHAM C. LUKE, MO.	4900 F	astern Ave., Bal	HMA	7172					
			TOTELA TEL., DA	ii. Pio,	-146	<u> </u>				
	DECT 9 1994 Jan 22. TEGISTBAR'S ST	artall								
	5201 001									

BALTIMORE, MARYLAND 21215-0020

uurs after death. Page 6 may be retained by the hospital or attending physician.

in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should

DWISION OF VITAL RECORDS, P.O. BOX 68760,

THE CLAN The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the ho	TO THE FUNEW DIRECTOR And the cert care leas been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to find within a commandation or command.	IMPORTANT: Il inmented, or ilem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
THE HOSPITM OR WITHOUT	THE FUNETAR DIRECTOR A	PORTANT: II INMESSED

	1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT (OF HE	ALTH AND	MENTAL HYGIEN				
	1. DECEDENT'S NAME (First, Middle, Last)		02.11111	IOAIL	0	DEATH	2. DATE OF DEATH			3. TIME OF DEATH	
	SHERMAN	R.		GR	OSS	JR.	DEC 1	5	YEAR Q 4	7.52 PM	
- 1	4. SOCIAL SECURITY NUMBER		(In yrs. lest birthday)	IF UNDER 1 Y	_	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTH	PLACE (State or Foreign	
	217-80-4081 9a. FACILITY NAME (If not institution, give s	-8	29 _{YRS.}			HOURS MIN.	OCT . 22,			RYLAND	
HOL	1000 BLK HILLM	,				ORE CI		9c. COU	N/A		
FUNERAL DIRECTOR	10e. STATE 10b. COUNTY	n/a	10c. CIT	Y, TOWN OR BAL	Ϋ́ÍМ	ÖRE			10d. INSIDE CITY VIMITS? I YES 2 NO		
ERAL	100. STREET AND NUMBER 3633 OLD MILFORD MILL RD. 21207 UNITED										
BY FUN	11. MARITAL STATUS Never Married 2 Married Married	12. WAS DECEDENT EVER I FORCES? I YES IF YES, GIVE WAR OR D		If y	S DECEI	ify Cuban, Maxica	NIC ORIGIN? (Specify Yearn, Puarto Rican, etc.)	or No—	14. RACE Black Specif	- American Indian, i, Whita, atc.	
	15. DECEDENT'S EDUC (Specify only highest grade	completed)	16a. DECEDENT'S (Give kind of a life. Do NOT us	vork done duri	ring most	of working	16b, KIND OF BUS				
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	LABORE	P_RE	MILE		BAL	TIMO		OUSING CITY	
_	17. FATHER'S NAME (First, Middle, Lest) SHERMAN	GROSS S	R.				ME (First, Middle, Maiden GINA JO	Sumame) HNSO	N		
BE	19a. INFORMANT'S NAME (Type/Print)			ADDRESS (S	Street and	d Number or Rural	Route Number, City or Town	n State Zin	Code)		
2	REGINA J	OHNSON	272		ARV					21225	
	20f. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other piece)										
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENȘEE	MT. ZI			ADDRESS OF FA		ANSD	OWIN	E/ ND	
	bee V.	Hollan		WM	. 0	. MARC	H FH11	01	Ε.	NORTH AVE.	
N	23. PART J. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death of the province of the control of the province of the										
CERTIFICATION	Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury thet Initiated eventa resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):										
PHYSICIAN: MEDICAL C	PART ii. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS ANALIBLE PRIOR TO COMPLETION OF CAUSE OF PEATH? 1 YES 2 NO										
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 28. PLACE OF DEATH (Check only one)										
2	EXAMINER?	HOSPITAL:		OTHER:		-0	11220.00				
É	27. MANNER OF DEATH	26a. OATE OF INJURY	26b. TIM		g Home Sc. INJUR		28d. DESCRIBE HOW II		ENE		
- 10	I Netural 5 Pending	(Month, Day, Year)	FK 174	URY	WOR	(7 V	84 612 03	L ch	7		
	2 Accident Investigation 3 Suicida 6 Could not be	280. PLACE OF INJURY	- At home, larm, a	treel, factory,	, offica	-1	281. LOCATION (Street a	nd Number	or Rural R	oute Number,	
	Homicide determined	building, atc. (Spec					1000 Town, State)	14/1	mon.	Street-	
COMPLEIED		CIAN: To the best of my know					to the cause(s) and man	ner as atate	Balt	him Marel	
AND CIONATURE OR DESCRIPTION A								d due to the	cause(s)	and menner as stated. /	
	29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO	O COMPLETED CAUSE OF DE	m (8)	Deline)	2	O.C.M.				(Month, Day, Year) 6,1994	
	THEONOREA	1. King	111 F		Str	ceet, E	Baltimore	, Ma	ryl	and 21201	
	DECT 9 1994 A	LIN CONNECTION NO	Late								

CAUSE (Disease or Injury that initiated events resulting in death) LAST

27. MANNED OF DEATH

1 Natural

2 Accident 3 Sulcide

4 Nomicide

BE COMPLETED BY FUNERAL DIRECTOR

2

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

68760	
BOX	
P.O.	
RECORDS,	
F VITAL	
VISION 0	
0	

TO THE-HESPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

											9	Ļ	37408	
1 - FOR STATE REGISTRAR		STATE OF MA				MENT OF I				IYGIENI IEG. NO.	E			
1. DECEDENT'S NAME (First,		,		·					2. DATE OF	DEATH	Y	YEAR	3. TIME OF DEATH	
Mere		Leon		TIR		X			12	0	9	94	0049AM	
4. SOCIAL SECURITY NUMB 043-24-9589		5. SEX 1 M 2 F	B. AGE (In you		1	UNDER 1 YEAR	HOURS	MIN.	7. DATE OF E (Month, Da	y, Year)	,	Counti	IPLACE (State or Foreign IV) IECTICUT	
96. FACILITY NAME (If not in	Regio	reet and number)	pitz	1	96	L24F			ATH		9c. COL	INTY OF D	Georges	
10a. STATE	10b. COUNTY	,		10c.	CITY. TO	OWN OR LOCA	TION						10d. INSIDE CITY	
MARYLAND	P	RINCE GEO	RGE		•	LAUREL						12	LIMITS?	
10a. STREET AND NUMBER						10	. ZIP CODE				10g. CI1	IZEN OF V	WHAT COUNTRY?	
7019 FITZPA	TRICK	DRIVE					20	707			1	USA		
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yes or No.— 14. RACE — Art														
	EDENT'S EDUC highest grade		164	(Give kind	of work	UAL OCCUPATE done during me	ON ast of working	7	16b. KIN	D OF BUS	INESS/IN	DUSTRY		
Elementary/Secondary (0	-12)	College (1-4 or 5 +)		life. Do NOT use retired.)										
12		_1		SALES MANAGER				CONSOLIDATED CHOCOLATE				CHOCOLATE		
17. FATHER'S NAME (First, M LEON GIROUX							ALL CALL		ME (First, Middl					
19s. INFORMANT'S NAME (7				405 14411		22722 10			CE CHAI					
GENEVIEVE L		IIX				PTT7.P							AND 20707	
20a. METNOD OF DISPOSITI			20b. PL /			ISPOSITION (N			DATE	7		- Cify or To		
1 Burisi 2 Crematio 4 Donation 5 Other		oval from Stats	BAL 1	IMOR	er other E W	ASHING	TON C	REM	12/1				ARYLAND	
21. SIGNATURE OF FUNERA	E SERVICE LIC	EHSEE	0			22. NAME A	ND ADDRES	S OF FAC	SUTY FLI	ECK I	UNE	RAL H	HOME, INC.	
1	Deco	De Coas	6,			760	1 SAN	DY S	SPRING	ROAI), L	AUREI	, MD 20707	
23. PART I. Enter the di shock, or h	seases, or s	omplications that	caused the	death. D	o not	enter the mo	de of dyin	ng, such	as cardiac	or respir	atory as	rest,	Approximate Interval Between	
IMMEDIATE CAUSE (Fin disease or condition resulting in death)			1	\sim	OF):	ary	A	re	st.				Onset and Death	
Sequentially list condit if any, leading to imme- cause. Enter UNDERLYI CAUSE (Disease or Inju- that initiated events	diate NG	Des	HAS A CON	tes	1	nel	eite	is	·					

PART II. Other significant conditions contributing to death but not resulting in the underlying rocture

24s. WAS AN AUTOPSY PERFORMED?

34b. WERE AUTOPSY PINDS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) 1 YES ZENO

1 | Inpatient 2 | ER/Outpetient 3 | DOA 28s. DATE OF INJURY

28c. INJURY AT WORK?

1 YES

OCR

29e. CERTIFIER t CERTIFYING PNYSICIAN: To the 2 MEDICAL EXAMINER: On

29c. LICENSE NUMBER

14201 Laurel Park.

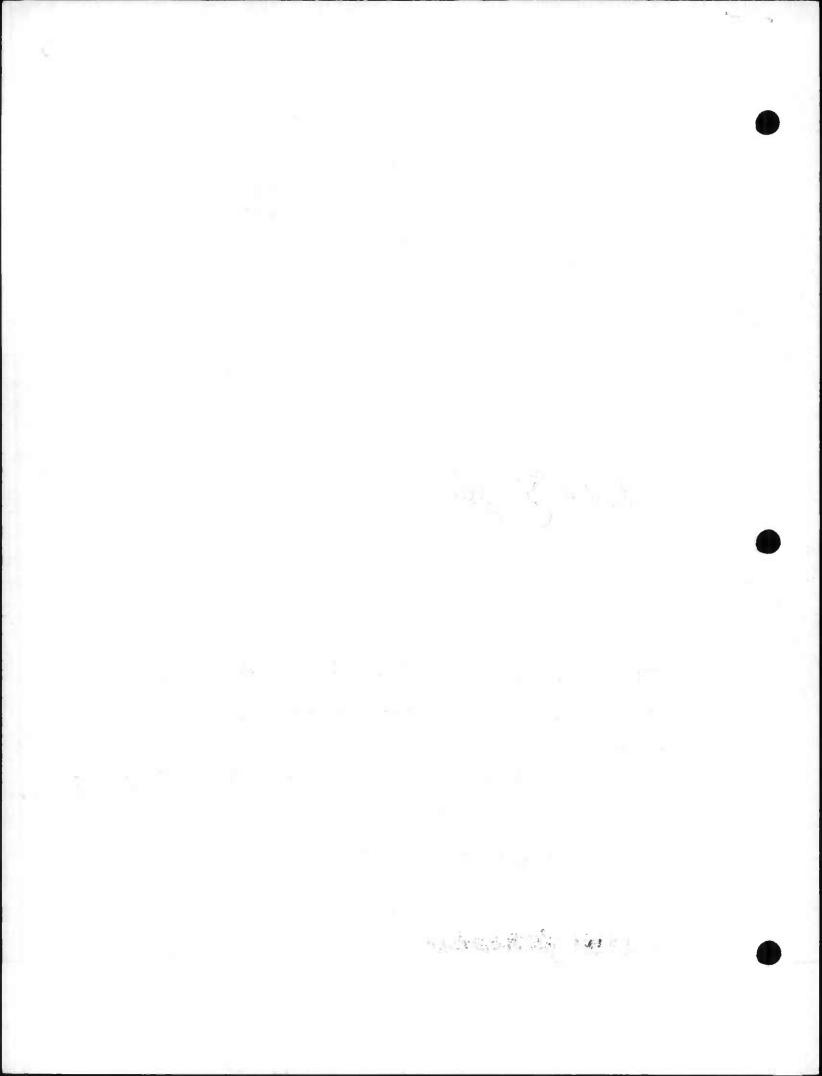
29d. DATE SIGNED (Month, Day, Year) 12-09

ETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)

Investigation

8 Could not be determined



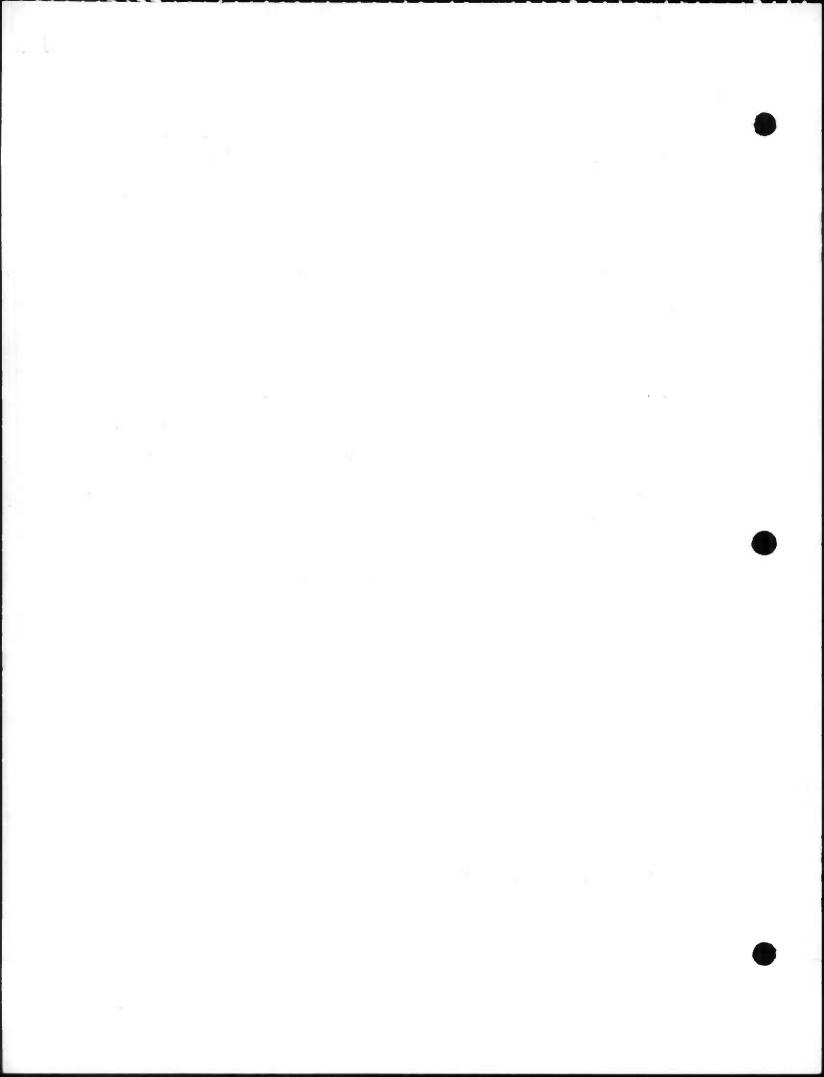
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE CHICAGO IN THE PARTY OF THE
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CERTIF	FICATE OF	DEATH	RE	EG. NO.			
	1. OECEOENT'S NAME (First, Middle, Last)					2. DATE OF O		2		3. TIME OF OEATH
	BESSIE M.	HUDSON				DECEMI	DAY RED		YEAR QQ/i	1 A.M. M
	4. SOCIAL SECURITY NUMBER		NGE (In yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7 DATE OF B	IRTH			IPLACE (State or Foreign
	212-28-9703	1 M 2 XF	YRS.	MONTHS DAYS	HOURS MIN.	8/11/1	Year)	- 1	Countr	ĞİNIA
. 3	9e. FACILITY NAME (If not institution, give str	reet and number)		96. CITY, TOWN	OR LOCATION OF D		1	9c. COUN		
8	346 HIGHLAND DRI	VE		GLEN E	URNIE, M	D.		ANNE	ARI	UNDEL
DIRECTOR	RESIDENCE OF DECEDENT							1111111		
2	100-00			TY, TOWN OR LOCA					i	10d, INSIDE CITY LIMITS?
	MARYLAND		B	ALTIMORE	-					1 YES 2 NO
RA	10e. STREET AND NUMBER		10	1. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?			
FUNERAL	3936 PENHURST ST				21215			US		
5	1 Never Merried 2 Merried	12. WAS DECEDENT EV FORCES? 1 1	res 2 NO		CENDENT OF HISPAI molfy Cuban, Mexico			or No-		E — American Indian, k, White, etc.
B	3 🐰 Widowed 4 🗌 Divorced	IF YES, GIVE WAR	OR DATES	1 🗆 YE	NO Specif	y:			AFR.	. AMERICAN
E	15. DECEDENT'S EDUC			S USUAL OCCUPATI		16b. KIND	OF BUSI	INESS/INDL		
ш	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of life, Do NOT u	work done during muse retired.)	ost of working					
MPI										
COMPLET	17. FATHER'S NAME (First, Middle, Last)				16. MOTHER'S NA	ME (First, Middle	, Maiden S	lurneme)		
BE	JAMES ROBINSON				PEARL	ROBI				
2	19a. INFORMANT'S NAME (Type/Print)				and Number or Rural					
	PEARL LEE				ST. BAL					
	1 St Buriel 2 Cremetion 3 Remo	val from State	cometery, cremetory or CEDAR HIL	OF DISPOSITION (Nother place)	ame of	DATE		ATION — C		
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	CEDAR HIL		ND ADDRESS OF FA	CILITY	BRUC	OKLYN	, MI	J.
	1	11 82+	7	ESTER	BROTHER	S FUNE	RA1 I	HOME,	P./	Α.
_	Jugar 1	n. all	2/		EUTAW PL					. 21217
1	23. PART I. Enter the diseases, or co shock, or heart fallure. L	omplications that cause of	n each line.	not enter the me	ode of dying, auc	h as cardiac	or reapin	atory arre	eat,	Approximate Intervsi Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death) Due to (or as a consequence or): Associated severe Angroupe 9									
		DUE TO (OR	AS A CONSEQUENCE O	Cere	-e 14	لمد را دي	109			
CERTIFICATION	Sequentially list conditions, The TO (OR AS A CONSCIUENCE OF).									
AT	if any, leading to immediate cause. Enter UNDERLYING	, , , , ,								j
Ē	CAUSE (Disease or injury that initiated eventa	DUE TO (OR	AS A CONSEQUENCE O	OF):						1
F	resulting in death) LAST									
	PART II. Other algolificent conditions	contributing to dea	th but not resulting	in the underlyle	a course alven in	Dort I 240	WAS AN A	UZOBOV	100	, WERE AUTOPSY FINDINGS
MEDICAL	Congeth		J 5411	/www	A cease diseil iii		PERFORM	MED?	/ 240,	AVAILABLE PRIOR TO COMPLETION OF CAUSE
	()		7		,	— ¹ 🗆	YES 2	MO		OF DEATH?
	DID TOBACCO USE CONTR	IDLITE TO CALISI	E OF DEATH V	EC EL NO E	UNCERTAI					1 Tes 2 DING
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	IBUTE TO CAUSI		ATH (Check only one,	UNCERIAI	иЦ				
SC	EXAMINER?	HOSPITAL:		OTHER:	ne 5 M Residence	a 🗆 au				
H	27. MANNER OF DEATH	28e. DATE OF INJU	IRY 28b, TII	ME OF 26c. IN	URY AT	26d. DESCRIB		JURY OCC	URED	
	1 Netural 5 Pending	(Month, Day, Ye	ear) IN	JURY W	YES 2 NO	-,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
BY	2 Accident investigation 3 Suicide 6 Could not be	26e, PLACE OF INJ	JURY — At home, ferm,	atreet, tectory, offic	•	281. LOCATION	(Street en	nd Number (or Rural F	Route Number,
Ĕ.	4 Homicide determined	building, etc.	эреспу)			City or Tow	m, State)			
٦	290. CERTIFIER (Check only 1 CERTIFYING PHYSIC	IAN: To the best of my l	nowledge, death occur	red at the time, date	end place, and due	to the cause(e)	and mann	nor on etela	ed.	
COMPLETED	one) 2 MEDICAL EXAMINER) and manner se stated.
Ü U	29b. SIGNATURE AND TITLE OF CERTIFIER	d			29c. LICENSE NUI					(Month, Day, Year)
@	El wend	Jenn			7791	7/		► /2	2 - /	7- 5 Y
유	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF	F DEATH (ITEM 27) (Type	e, Print)	4111			- /		
		ahart	noon	1	feu /	3000	10	, M	10	2106/
	DECL 9 1994	32. REGISTRAR'S S	RAL M							

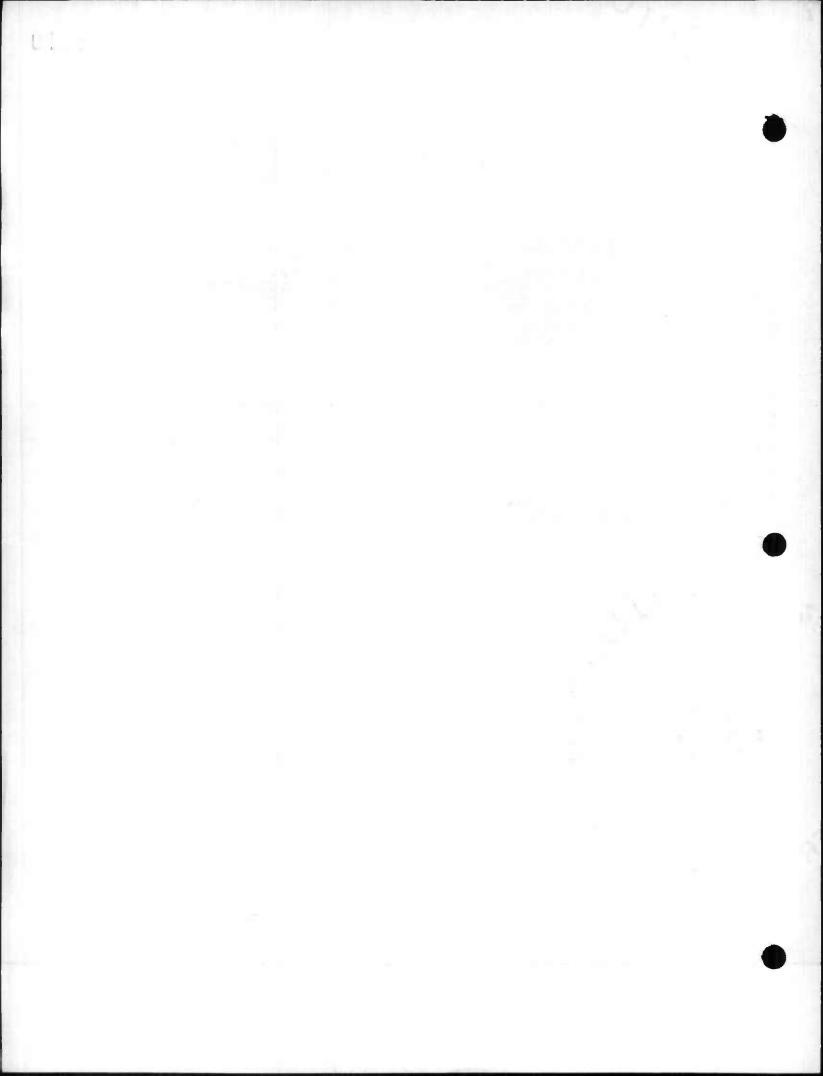


STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR 300/0M December 1994 7. DATE OF BIRTH (Month, Day, Year, 4 SEY 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 88 N.C 01-5998 1 M 2 | F 5/31/ permit. Pages 1, 2, 3 should Sa. FACILITY NAME (If not institution, give street 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH FUNERAL DIRECTOR x kesville sarroll RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Mary laxa Carroli Kesville 1 YES 2 | NO 10a. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 7309 ecoxdAve. 21784 the funeral director, page 5 should be detached for use as the burial-transit rours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. BALTIMORE, MARYLAND 21215-0020 YES 2 AR OR DATES FORCES? 2 NO 1 Never Married 2 Married F YES, GIVE ВҰ 1 TES 2 NO Specify Specify: 3 Widowed 4 Divorced AMERICAN AFR COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) LABORER RETIRED notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) SAMUEL HALEY IDA HALEY BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 EARLENE SMOOTH 717 DRUID PARK LAKE DR, BALTO. MD. 21217 1308 Pe 20a. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, State OATE 1 # Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) must ALTO. NATIONAL BALTO. MD. 12/13/94 medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME P.A. 1300 EUTAW PL. BALTO. MD. 21217 removal 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. been signed by the attending physician and completely filled in by it. of Health and Mental Hygiene prior to burial, cremation, or remo Approximate interval Betwe IMMEDIATE CAUSE (Finei Onset and Death or other traumatic event, the disease or condition Alumonia executed within resulting in death) DIVISION OF VITAL RECORDS, P.O. BOX 68760, PUE TO (OR AS A CONSEQUENCE OF): Armic Ilna PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST tem 23 shows any injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? 1 YES 2 NO has be Dept. HOSPITAL OR ATTENDING PHYSICIAN: The law 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) After this certificate death with the State HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA OTHER 1 WES 2 NO rsing Home 5 - Residence 8 - Other (Specify) 4 PIN marked, or 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY --- At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) DIRECTOR: A hours after d 00 COMPLETED 6 Could not be Item 28 4 Homicide 29a. CERTIFIER

1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner se stated. FUNERAL I IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, do occured at the time, date and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIQNEO (Month BE · 포포를 Ita ona nD 94 8 223 2 EO CAUSE OF DEATH (ITEM 27) (Type, Print) istratown Busine onathan 31. DATE FILED (Month, Day, Year)
DEC1 9 1 32. REGISTRAR'S SIGNATURE Newstern Rand 12

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL CERTIFICATE OF DEATH	HYGIENE REG. NO.
n	ECEDENT'S NAME (First Alidello I set)		

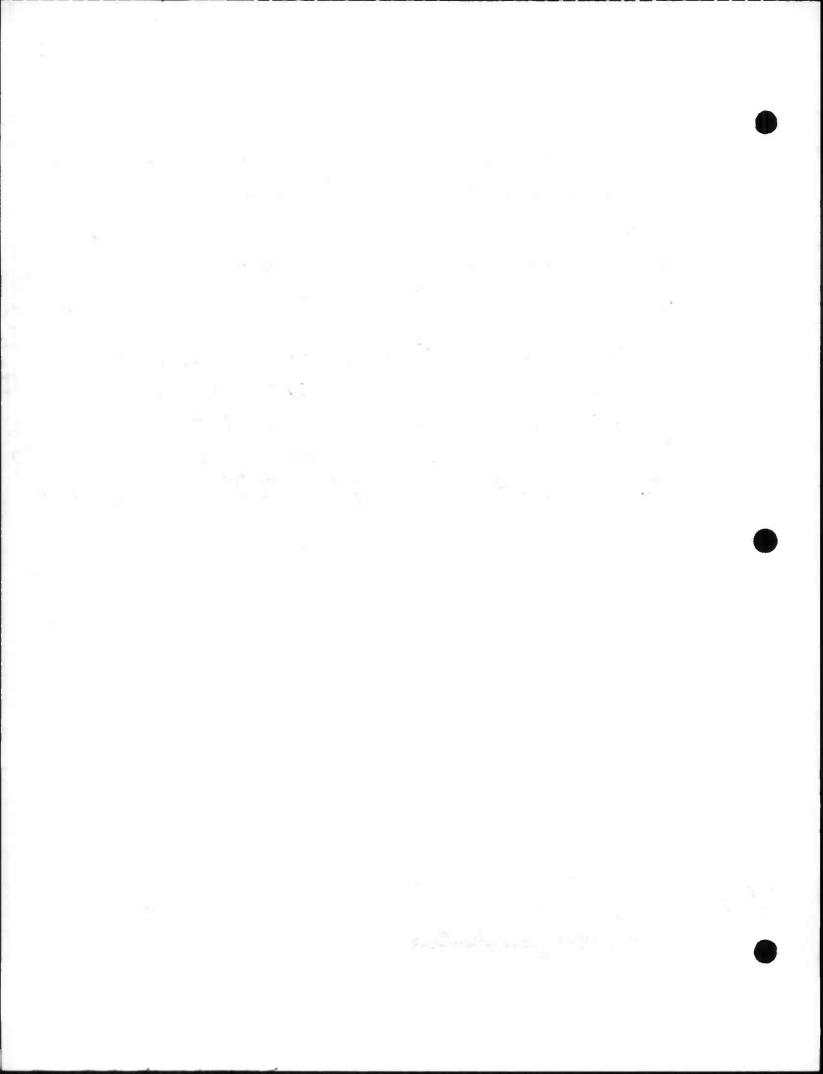
		1 - STATE STATE CF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
		1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH	_								
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 MRS 7. DATE OF BIRTH 8. BIRTHDI ACE (State or Consider	M								
p		212-20-9857 1 M 2 M F 69 YRS. MONTHS DAYS HOURS MIN. May 28, 1925 Country Maryland									
3 should	E E	9a. FACILITY NAME (If not Institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH UNION MEMORIAL BALTIMORE CITY 9c. COUNTY OF DEATH									
s 1, 2,	CTOR	RESIDENCE OF DECEDENT	_								
iri. Pages	DIRE	Maryland Baltimore City Baltimore City Baltimore City Sign Fig. (INSIDE CITY LIMITS? 1 ♥ YES 2 □ NO									
sit permit.	FUNERAL	100. STREET AND NUMBER 2801 East Strathmore Avenue 101. ZIP CODE 21214 United States									
020 physician. bunal-transit	F S	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Married 2 Married FORCES? 1 VES 2 X NO 1 Never Married 2 Married Block, White, atc.	_								
215-0020 attending physic se as the burial	B	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: White									
or atten	TED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) [Glaw kind of work done during most of working life. D. NOT use retired.) [Bloom 15. DECEDENT'S USUAL OCCUPATION (Glaw kind of work done during most of working life. D. NOT use retired.)									
the hospital detached to once.	COMPLET	8 Dependent									
ज देव	BE CO	17. FATHER'S NAME (First, Middle, Last) Phillip P. Heil 18. MOTHER'S NAME (First, Middle, Malden Surname) Martha Mae Smallwood									
5 S S	TO .	198. INFORMANT'S NAME (Type/Print) Marcella D. Eibner 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2801 E. Strathmore Ave. Baltimore, Md. 21214									
Page 6 may be ral director, page liner must be		20s. METNOD OF DISPOSITION 1 X Burlel 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of competery, grametory on other place) Parkwood Cemetery 12/21/94 Baltimore Maryland									
death. Page funeral direc		21. SIGNATURE OF FUNERAL SERVICE LICENSEE MILTON J. Knight Jr 22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc.	_								
×		Multon 5305 Harford Road Baltimore, Md. 21214									
ours or re		23. PART I. Enter the diseases of complications that cause disease or condition Approximate interval Betwee Onset and Deat disease or condition Approximate interval Betwee Onset and Deat disease or condition									
ted within completely fille ial, cremation, event, the		disease or condition resulting in death) a. Schould Carelia nytopathy DUE TO (OR AS A CONSEQUENCE OF):	_								
UX 687.1 be executed sician and confior to burial, traumatic ex	NO	Sequentially list conditions, b. Insulus dysendent DM DIJE TO JOR AS A CONSEQUENCE OF THE TOTAL ACCORDING TO THE T									
be be ior to ior to raur	RTIFICATIO	aury, leading to immediate aurage aurage. Enter UNDERLYING AUSE (Disease prinjury									
ending Property	ERTIF	that initiated events resulting in death) LAST d.									
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T = 0 = -	EDICAL	PERFORMED? 1 YES 2 NO COMPLETION OF CAUSE OF DEATH?									
w requires that been signed pt. of Health a	Σ	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN D									
The lante has ate De ate De ate De ate De	CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:	_								
ICIAN: sertifica the St	PHYSICI	1 YES 2 1 Inpettent 2 ER/Outpettent 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER DF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED	_								
After this death with imarked	ВУ Р	1 Natural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO									
	ED	3 Suicida 8 Could not be datarmined 28s. PLACE OF INJURY — At home, farm, atreet, factory, offica building, atc. (Specify) 28s. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
Say.	COMPLET	29a. CERTIFIER (Check only one) CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and menner as stated.									
HOSE William MATC		2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER									
TO THE HOSE TO THE FUNCTION DE FREI WITHE	TO BE	2-JEHA PGY-1	j								
6		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type. Print) PLINA JEHA, UNION MEMORIAL HOSPITAL									
		31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 32. REGISTRAR'S SIGNATURE									

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OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Oept. of Health and Mental Hypiene prior to burial, cremation, or removal. PORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYLAND	/ DEPARTMENT OF I	HEALTH AND I	MENTAL HYGIENE REG. NO.					
	1. DECEDENT'S NAME (First, Middle, Last)		4		2. DATE OF DEATH MONTH DAY	3. TIME OF DEATN				
	GRACE MARIA	AM HARI			DECEMBER 15	- 1984 11:50 PM				
	A. C ah and a	5. SEX 6. AGE (In yrs. 10 M 2 XF 70	YRS. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN,	7. DATE OF BIRTH (Mapth, Day, Year)	8. BIRTNPLACE (State or Foreign Country) 24 Marylan d				
DIRECTOR	96. FACILITY NAME (If not institution, give street and number) 1									
REC	10a. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCA	TION		10d. INSIDE CITY LIMITS?				
	Mary land		Balti	none		YES 2 NO				
FUNERAL	3032 QUILLO	rd avenue	.10	Of. ZIP CODE	100	CITIZEN OF WHAT COUNTRY?				
S	11. MARITAL STATUS 1	2. WAS DECEDENT EVER IN U.S.	ARMED 13. WAS DE	CENDENT OF NISPAN	IC ORIGIN? (Specify Yee or N	o- 14. RACE — American Indian,				
ВУ Е	1 Never Married 2 Merried 3 Widowed 4 Divorced	FORCES? 1 TYES 2 FIF YES, GIVE WAR OR DATES		pecify Cuban, Mexices S 2 NO Specify		Black, White, etc.				
	15. OECEDENT'S EDUCAT	TION 16a.	DECEDENT'S USUAL OCCUPAT	ION	16b. KINO OF BUSINES	1 DIACK				
COMPLETED	(Specify only highest grade col	mpleted)	(Give kind of work done during m life. Do NOT use retired.)	ost of working	0 4	5				
MPL	8+4 4	10 3	ocial Wo	rker	City of	Battimore				
8	17. FATHER'S NAME (First, Middle, Lost)	carl		18. MOTHER'S NAI	WE (First, Middle, Malden Street	ime)				
BE	19e, INFORMANJ'S NAME (Type/Print)	/	19b. MAILING ADDRESS (Street	end Number or Burel S	Poute Number, City or Town, Sta	ite, Zip Code)				
5	SANDY Harris		3032 QUI	ford ave	- Batto M	1 2/2/8				
	20e METNOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remova	20b. PLAC	EAND DATE OF DISPOSITION (N	ame of	MATE 200 LOCATIO	ON — City or Town, State				
	4 ☐ Donation 5 ☐ Other (Specify)	of from State cemetery k	resievi of	ar	194 Coffer	ISULTE, ME				
	Dank 4	DID	205	ND ADDRESS OF FAC	Russ fon	eral Home				
	gargen a	- Tuis		aw nor	th que, Ba	Ho M 21216				
		at only one cause on each li	na.	oda of dying, such	n as cardisc or reapirator	Intarvel Between				
	IMMEDIATE CAUSE (Final disease or condition resulting in death) e. CARDIAC TAMPONADE									
	e. CARDIAC TAMPONATIC BUE TO (OR AS A CONSEQUENCE OF):									
S	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
ITK.	cause. Enter UNDERLYING CORONARY ARTERY PREPARE									
Ē	CAUSE (Disease or Injury that Initiated eventa	DUE TO (OR AS A CONS	SEQUENCE OF):		0.100	1091				
CERTIFICATION	resulting in death) LAST									
AL 0	PART II. Other aignificant conditions of	contributing to daeth but no	t rasulting in the underlyin	g cause given in	Part I. 24a. WAS AN AUTO PERFORMED					
PHYSICIAN: MEDIC					1 TES 2 KN	COMPLETION OF CAUSE				
ME						1 TES 2 NO				
AN	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO LUNCERTAIN 125. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
Sici	EXAMINER?	IOSPITAL:	OTHER:							
ž	27. MANNER OF DEATN	28a, DATE OF INJURY	28b. TIME OF 28c. IN	JURY AT	8 Uther (Specify) 28d. DESCRIBE NOW INJUR	Y OCCURED				
ВУР	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)		YES 2 NO	-					
	2 Accident 3 Suicide 8 Could not be datermined 4 Nomicide Could not be datermined 28a. PLACE OF INJURY — At home, farm, atreet, factory, office City or Town, State) 28b. LOCATION (Street and Number or Bural Route No. City or Town, State)									
COMPLETED	29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER.	IN: To the best of my knowledge,	death occurred at the time, date	end place, end dua	to the cause(e) end manner e	e stated,				
	29b. SIGNATURE AND TITLE OF CERTIFIER	on the been of examination and/o	www.gatton, in my opinion,			fo the cause(e) end menner as stated.				
BE	200 Mel	PHV.	SICIAN	AT 2 UZ	7946 A12 D	DECEMBER 16, 1994				
2	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF CEATH (IT	TEM 27) (Type, Print)	2436	8946 A13 D	December 10/14/				
	6914 LACH	AN CIRCL	E#L	Balty	mone, M	D. 21239				
	7 DEC1 9 1994	Lin Deudeorhard	at							



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PHYSICIAN: MEDICAL

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31. DATE FILED (Month, Day, Year)

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit perm be filed within 72 hours after death with the State Deot, of Health and Mental Hydiene prior to burial, cremation, or removal.	IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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Item # 1 Film # G 718 12-19-94 N.A Per Funeral Home STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH MONTH Sanders William Holden 3:150 " 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTN (Month, Day, Year 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 - F DAYS 17-26-9315 EB 1422 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN MEDICAL BALTIMORE IBERTY ENTER DECEDENT RESIDENCE OF 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD BALTIMORE YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? MOUNT N. 223 21 LAZ.U 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—It yes, specify Cuban, Mexicen, Puarto Rican, stc.) 1 Never Merried 2 Merried 14. RACE — American Indian, Black, White, etc. 1 TYES 2 NO Specify Specify! 3 Widowed 4 Divorced 1944-JAN. ACK 1941 JULY 15. DECEDENT'S EDUCATION 18e, DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest go entary/Secondary (0-12) College (1-4 or 5+) I TRASH 644 KEMOVAL 17. FATNER'S NAME (First, Middle, Last) Maiden Sumame) W. HOLDEN MAGGIE OHN INTON INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Tox MA Hou -DEN MOU 21223 20a_METHOD OF DISPOSITION 1 & Burial 2 Cremation 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LQCATION - City DATE 3 - Removal from State VET, CEM 12219 Donation 5 - Other (Specify) 21 SIGNAT OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
WARLE HOUSEAL HOME-WEST 51215 AVE BINCTO. MC 4300 WABASH 23. PART I. Entar the diseases, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between IMMEDIATE CAUSE (Final **Onaet and Death** disease or condition resulting in death) motortatic dung Cancer DUE TO (OR AS A CONSEQUENCE OF): ton sign NU Sequantially list conditions. DUE (OR AS A CONSEQUENCE OF): if any, leading to immediata Vo cause. Entar UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evants resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? PERFORMED? 1 ☐ YES 2 ☐-MO 1 - YES 2 - H DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\Boxed{1}\) UNCERTAIN \(\Boxed{1}\) 25. WAS CASE REFERRED TO MEDICAL 28. PLACE DF DEATN (Check only one) EXAMINER? HOSPITAL: OTHER:
4 □ Nursing Home 5 □ Raeldence 8 □ Other (Specify) 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Watural Pending 1 YES 2 NO 2 Accident Investigation 28e. PLACE OF INJURY — At home, term, street, factory, office 28t. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide a Could not ba 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end piece, end due to the ceuse(e) end menner ee stated. 2 __ MEDICAL EXAMINER: On the baels of examination end/or investigation, in my opinion, death occured at the time, date end place, and due to the cause(e) and menner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Derace anino D37203 12.15 .94 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 27) (Type, Print)

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BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending physicia	ed in by the funeral director, page 5 should be detached for use as the burial-to, or removal.	medical examiner must be notified at once.
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Pages 1, 2, 3 should

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH ROBERT DEC S. HINES 06 1994 10:47 PM 7. DATE OF BIRTH 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year) 04-30-66 1 M 2 - F DAYS HOURS VRS 9e. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR MARYLAND SHOCK TRAUMA BALTIMORE CITY RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 NO FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? STONE MARK 2111 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No If yes, specify Cuben, Mexicen, Puerto Rican, atc.) 11. MARITAL STATUS If yes, specify Cube 1 Never Merried 2 Merried Specify: BY 3 Widowed 4 Divorced BE COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 166. KIND OF BUSINESS/INDUSTRY ry/Secondary (0-12) College (1-4 or 5+) 4INES 19b. MAILING ADDRESS (Str 2 PO. METHOD OF DISPOSITION 20b. PLACE AND DATE OF DISPOSITION Buriel 2 Cremetion 3 Ren Donation 5 Other (Specify) 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate ahock, or haart fallure. List only one cause on each line. Interval Batween IMMEDIATE CAUSE (Final Oneat and Daeth disease or condition MULTIPLE INJURIES resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF)that initiated evanta resulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? TYES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL:
1 X Inpatient 2 ER/Outpatient 3 DOA OTHER: 1X YES 2 □ NO 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 25e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY 1 Natural Pending Investigation 9:55 P 12/6/94 M 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, Ierm, street, lectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number City or Yown, State) 2704 PROSPECT ST. BALTIMORE CITY 3 Suicide 8 XXCould not be COMPLETED 4 Homicide HOUSE 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner se stated. 2 🕅 MEDICAL EXAMINER: On the beele of exemination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ee atated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month, Day, Year) ▶DEC 07,1994 OCME 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Fayler Jahren 111 Penn Street, Baltimore, Maryland 21201

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P.O.	
RECORDS,	
OF VITAL	
DIVISION	

		1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.					
YLAND 21215-0020 by the hospital or attending physician. be detached for use as the burlat-transit permit. Pages at once.		11 Min B	T. HACKNE s. Sex 6. AGE (in yrs. last	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2. DATE OF DEATH MONTH DEC. 7. DATE OF BIRTH (Month, Day, Jay)	19 9	3. TIME OF DEATH M BIRTHPLACE (State or Foreign Country)
	стоя		et and number)	9b. CITY, TOWN	OR LOCATION OF DE	EATH S	9c. COUNTY	OF DEATH
	DIRE	10a. STATE 10b. COUNTY		16c. CITY, TOWN OR LOC	IMORE			10d. INSIDE CITY LIMITS? 1 X YES 2 NO
	FUNERAL	10e. STREET AND NUMBER 4508 ROKEB	12. WAS DECEDENT EVER IN U.S. ARIN		2122	29	4.	of What Country?
	B	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES 2 NO. IF YES, GIVE WAR OR DATES	O If yes, s	ECENDENT OF HISPAL specify Cuben, Mexica S 2 NO Specif	an, Puerto Rican, etc.		RACE — American Indian, Black, White, atc.
	COMPLETED	1214		EDENT'S USUAL OCCUPAT the kind of work done during in the profiles retired.)	nost of working	Farm	BUSINESS/INDUŚ	GOV 7.
	w w	17. FATHER'S HAME (FINE, MICHIN, LANS) THE MACHINE (NOOFFINE)	KNEY	Man and Appears of	NAV.	ny A	gcKvz	Y
page .	TO BI	ROBELT Pau	514 4	MAILING ADDRESS (Scool)	KEBY F	B. B.J.	MD,	21229 or Town, State
ALTIMOR death. Page 6 m funeral director,	administration in the state of	20. METHOD OF DISPOSITION 1 Burlat 2 Creptation 3 Remove 4 Donatton 5 Other (Specify) 21. SIGNATURE OF SEWERAL BETWICE LICEN	HAK	מומת אין קטומת מים	ENT TH	ARCH TO	ANTON MERA/	ACMENA,
within 24 r	on, me menter	23. PART Entrito diseases, or continued to the continued to the condition resulting in death)	mplications that caused the deat only one cause on each line. Pneumonia DUE TO (OR AS A CONSEON		node of dying, suc	th as cardiac or n	pepiratory arrest	Approximate Interval Between Onset and Death
that the death certificate be executed by the attending physician and corn h and Merital Hygiene prior to burial, any Injury, or other traumatic evical.	ERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Multistroke disease DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic cerebrovascular disease DUE TO (OR AS A CONSEQUENCE OF): d.						
	MEDICAL	PART II. Other significant conditions	contributing to death but not re	sulting in the underlyl	ng cause given in	PER	S AN AUTOPSY IFORMED? S 2 NO	24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
SICIAN: The law certificate has but the State Dept.	PHYSICIAN:		HOSPITAL:	OTHER:	PLACE OF DEATH (Ch			
G PHYSICIA er this certi ith with the	ВУ РНУ	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)	INJURY	IJURY AT PORK? YES 2 NO	28d. DESCRIBE HO	OW INJURY OCCUR	ED
TTENDI STOR: A after d	1	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJURY — At hombuilding, etc. (Specify)	ne, farm, street, factory, off	Ice	281. LOCATION (Str City or Town, S		Rural Route Number,
3 7 K	COMPLETED	29s. CERTIFIER (Check/only) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated.						
TO THE HOSPIT TO THE FUNERA De filed within 7	TO BE O	29b. SIGNATURE AND TITLE OF CERTIFIER	Kallago	M	29c. LICENSE NUI	MBER 01.786	29d. DATE SI ▶ 1.2	IGNED (Morith, Day, Year) /16/94
in		Laurence R. Gall	lager, M.D. 345	55 Wilkens A	Avenue Ba	ltimore,	Marylan	d 21.229
V		31. DATE FILEO (Month, Day, Year) DEC1 9 1994	32. REGISTRAR'S SIGNATURE					

no see

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	FOR 1 - STATE REGISTRAR	STATE OF MAP		TMENT OF H		MENTAL HYGIENI	E		
3,	1. DECEDENT'S NAME (First, Middle, Last)		oz.m	IONIE OI	DEATH	2. DATE OF DEATH		3. TIME OF DEATH	
- 1	SHERRY LEE HARR	ING				DECEMBER 7		6:00 PM	
- 1	4. SOCIAL SECURITY NUMBER		GE (In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRT	HPLACE (State of Foreign my) COLUMBIA	
	579-58-6836	1 🗆 M 2 💢 F	50 YRS.			MAY 31, 19	944 DIS	TRICT OF	
œ	9a. FACILITY NAME (If not institution, give				R LOCATION OF DE	EATH	9c. COUNTY OF		
DIRECTOR	NIH, THE CLINIC	AL CENTER		BETHE	SDA		MONTGO	MERY	
RE	10e. STATE 10b. COUNT		100	Y, TOWN OR LOCA				10d. INSIDE CITY LIMITS?	
	MARYLAND Howa	ird	C1	LARKSVIL				1 TES 2 THO	
BRA	6814 REDBERRY RO	AD		100	21029			WHAT COUNTRY?	
FUNERAL	11, MARITAL STATUS	12. WAS DECEDENT EV	ER IN U.S. ARMED		ENDENT OF HISPAN	NIC ORIGIN? (Specify Yes	Or No.— 14. RAC	E — American Indian,	
BY F	1 Never Merried 2 Merried 3 Widowed 4 Divorced	FORCES? 1 1 1			2 X NO Specify	n, Puerlo Rican, etc.)	Spec	ck, White, etc.	
	15. DECEDENT'S EDI	ICATION	14. DECEDENT'S	USUAL OCCUPATION		465 KIND OF BUILD		WHITE	
	(Specify only highest grad		(Give kind of life. Do NOT u	work done during mo se retired.)	st of working	16b. KIND OF BUS	INESS/INDUSTRY		
AP.	12	4	TEACHE		Edu	cation			
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	-			18. MOTHER'S NA	ME (First, Middle, Maiden :	Surneme)		
BE	MICHAEL G. HARRI	ING				A E. MOORE			
2	190. INFORMANT'S NAME (Type/Print) MICHAEL G. HARRI	INC	1 .			Route Number, City or Town		ND 01000	
	20e. METHOD OF DISPOSITION		20b. PLACE AND DATE			DATE 20c. LOC	MARYLA CATION — City or T		
	1 Donation 5 Other (Specify)	noval from State	Balt. Was	ther place)		2-9-94 La			
	21. SIGNATURE OF FUNERAL SERVICE LE	CENSER		22. NAME A	ID ADDRESS OF FA	CILITY			
	1 (dago	X. bads	,	Fleck	Funeral	Home, Inc	· Tours1	M4 20707	
	23. PART Enter the diseases or shock, or hasrt failure.	Complications that day	hed the death. Do	not enter the mo	de of dying, suc	h es cerdiec or respir	ratory arrest,	Approximate interval Between	
	IMMEDIATE CAUSE (Final	Lot M-	Def.		tr.	0		Onset and Death	
	IMMEDIATE CAUSE (Final disease or condition resulting in death) Oue TO (OR AS A CONSEQUENCE OF): Onset and Death Onset and Death Oue TO (OR AS A CONSEQUENCE OF):								
2	Sequentially list conditions. Co. Renal Failure								
10	If any, leading to immediate								
CA	cause. Enter UNDERLYING CAUSE (Disease or injury	· hive	v Fail	we				1 WK	
CERTIFICATION	that initisted events resulting in dasth) LAST	DUE TO (OR	AS A CONSEQUENCE O	F):				i	
CER		d							
AL	PART II. Other aignificant condition	ns contributing to dea	th but not resulting	In the underlyin	g cause givan in	Part i. 24a. WAS AN PERFOR		. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO	
DIG						1 🖫 YES 2	□ NO	OF DEATH?	
Σ	DID TOBACCO USE	CONTRIBUTE T	O CALISE OF	DEATH V	ES NO			1 √YES 2 □ NO	
PHYSICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE 1	O CAUSE OF		ACE OF DEATH (Ch				
Sic	EXAMINER?	HOSPITAL:	Outpatient 3 DOA	OTHER:		6 Other (Specify)			
F	27. MANNER OF DEATH	26e. DATE OF INJU (Month, Day, Ye	IRY 28b. TIN	E OF 28c. INJ		28d. DESCRIBE HOW IN	JURY OCCURED		
ВҰ	1 Natural 5 Pending 2 Accident Investigation	DE/X	A34		rES 2 NO				
G	3 Suicide 6 Could not be 4 Homicide determined	building, etc.	URY — At home, ferm, (Specify)	street, factory, offic	'	261. LOCATION (Street e. City or Town, State)	nd Number or Rural	Route Number,	
COMPLETED	290. CERTIFIER 1 CERTIFYING PHYS	CIANA To the horse of our I							
MP	anal	SICIAN: To the best of my li ER: On the basis of examin						e) end manner ee stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIE				29c, LICENSE NUI			D (Month, Day, Year)	
BE	IN ORTUZE	+R MD			3<0637	54/04) inat	- 12/8	194	
2	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CAUSE OF	F DEATH (ITEM 27) (Type	, Print)		טטוזייל ייוו ב			
	WHLDO F. UR	TUZAR		ROCKVILL	E PIKE,	BETHESDA, 1	MARYLAND	20892	
	31. DATE FILED (Month, Day, Year)	Also Muster	CARRET					11 - 12	
	Prot o lead	a						3/47	

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ON OF VI	DING DHYNICIAN. The law requires that the death certificate he executed within 34 hours as
5	DING

ONDS, F.O. BOA 86760	G PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	er this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunia-transit permit. Pages 1, 2, 3 should the with the State Dept. of Health and Mental Hydlene prior to bunial, cremation, or removal.	origing the lam 92 share one interest the training as a market as a market as a collision of a constitution of
OF VIEW DECORDS, P.O. DOA 86/80)	PHYSICIAN: The law requires that the death certific	this certificate has been signed by the attending p with the State Dept. of Health and Mental Hygien	dead or item 23 shows any injury or othe

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR		CEF	TIFIC	ATE OF	DEATH	А	EG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF			3. TIME OF OEATH
	VIOLA E	LIZABET	1+)-	FILL		MONTH 12	DAY	94	3:05 P M
			E (In yrs. last bli	tholms) as	UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF E			
	4. SOCIAL SECURITY NUMBER 579-34-9887	1 □ M 2 1 F	0.0		ITHS DAYS	HOURS MIN.	(Month, De	y, Year)	S ^{Count}	Carolina
	9e. FACILITY NAME (If not institution, give st	reet and number)		9b	CITY, TOWN C	OR LOCATION OF D			JNTY OF C	DEATH
Œ	St. Agnes Hos	pital			Ва	ltimore	,			
DIRECTOR	RESIDENCE OF DECEDENT									
B	10e. STATE 10b. COUNTY		1	Oc. CITY. TO	WN OR LOCAT	ION				10d. INSIDE CITY
뜨	MD.		1			ltimore				LIMITS?
								12		1 (YES 2 NO
FUNERAL	10e. STREET AND NUMBER	1 0				ZIP CODE		10g. CI1		WHAT COUNTRY?
E	102 S. Kossut	n Street				21229			U.S	
5	11. MARITAL STATUS	12. WAS DECEDENT EVE	R IN U.S. ARME	0	13. WAS DEC	ENDENT OF HISPAI	NIC ORIGIN? (S	pecify Yes or No-	14. BAC	E — American Indien,
正	t Never Married 2 Merried	FORCES? 1 YE			If yes, sp	ecify Cuben, Mexica	n, Puerto Ricar		Blac	k, White, etc.
B≺	3. Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES		1 TYES	2 D NO Specif	y:		Spec	" Black
	15. DECEDENT'S EDUC	ATION	1.0 0000						<u> </u>	
COMPLETED	(Specify only highest grade	completed)	(Give	kind of work	AL OCCUPATION done during mo ired.)	DN st of working	16b. KIN	D OF BUSINESS/IN	DUSTRY	
ا ت	Elementary/Secondary (0-12)	College (1-4 or 5+)								
4	1000		rac	cory	Work	er				
ō	17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NA	ME (First, Middle	e, Meiden Surneme)		
	William Scot	t				Jane	Wood			
8	19e. INFORMANT'S NAME (Type/Print)		100 10	AH ING AD	DE00 (0)	-11				-
2	Richard Davi	0	19b. M	AILING ADI	DRESS (Street a	nd Number or Rural	Route Number, C	City or Town, State, Zi	ip Code)	21220
- 1	RICHARD DAVI	3	Τ,	02 3	. KUS	Such St	reet	Balto.	, MD.	21229
- 1	20e. METHOD OF DISPOSITION 1. Buriel 2 Cremation 3 Remo	2	06. PLACE AND	DATE OF D	SPOSITION (Na	me of	DATE	20c. LOCATION -	City or To	own, State
	4 Donation 5 Other (Specify)	oval from State	Cedar	oryH In I	T ^{ce)} Cem	etery l	.2/94	Glen 1	Burn	ie, MD.
- 1	21. SIGNATURE OF FUNERAL SERVICE LIC					ID ADDRESS OF FA				
- 1	Model	01-4						1721-	27 N	N.Monroe
- 1	Noutha.	Heiter C	ESP #:	281	E.L.	Phillip	S F/F	ST. B	alto	MD21217
\neg	23. PART I. Entar the diseases, or c	omplications that caus	ad the death	. Do not e	ntar tha mo	de of dving, auc	h as cardiac	or respiratory as	real	Approximate
- 1	ahock, or haart fallure. L	lst only one cause on	each lina.					or reapmetory an	1000,	Interval Between
H	IMMEDIATE CAUSE (Final									Onset and Dasth
- 1	disease or condition reaulting in death)		Drewn	nani	4					7 days
- 1		DUE TO (OR AS	A CONSEQUE	NCE OF):						-
z	Sequentially list conditions, Due to (OR AS A CONSEQUENCE OF):									
CERTIFICATION	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUE	NCE OF):	3					
ξI	cause. Entar UNDERLYING									
프	CAUSE (Disease or injury that initiated events	DUE TO (OR AS	A CONSEQUE	NCE OF):						
ΕI	reaulting in death) LAST									
與	d									
	PART II. Other algnificant conditions	contributing to death	but not raau	iting in th	e underivino	causa given in	Part i. 24a	. WAS AN AUTOPSY	246	. WERE AUTOPSY FINDINGS
EDICAL						, cooling grown in		PERFORMED?		AVAILABLE PRIOR TO
히							1	YES 2 NO		COMPLETION OF CAUSE OF DEATH?
¥					,					1 TYES 2 DHO
-	DID TOBACCO USE CONTR	BUTE TO CAUSE	OF DEATH	YES	NO E	UNCERTAI	v 🗆 l			
PHYSICIAN: M	25. WAS CASE REFERRED TO MEDICAL				heck only one)	OTTOLKIAN	1 -		1	
ᅙᆘ	EXAMINER?	HOSPITAL:		TO	HER:					
₹ X	1 TES 2 FNO	1 Inpetient 2 - ER/O		DOA 4	Nursing Hom	e 5 🗆 Reeldence	6 Other (Sp.	ecify)		
ᇎᅵ	27. MANNER OF DEATH	28e. DATE OF INJUR (Month, Day, Year		b. TIME OF INJURY	28c. INJ	URY AT RK?	28d. DESCRIE	BE HOW INJURY OC	CURED	
BY	t 🗹 Natural 5 🗌 Pending	, , , , , , , , , , , , , , , , , , , ,				ES 2 NO				
	2 Culate	26e. PLACE OF INJU	RY — At home,	term, street	, tectory, office	,	281, LOCATIO	N (Street end Numbe	r or Rural I	Soute Number
	4 Homicide 6 Could not be	building, atc. (S)	pecify)				City or To	wn, Stete)		
<u>□</u>										
COMPLETED	29e. CERTIFIER t CERTIFYING PHYSIC	CIAN: To the best of my known	owledge, death	occurred at	the time, date	end place, end due	to the cause(e)	end menner ee ata	rted.	
⋛∥	2 MEDICAL EXAMINER	: On the beele of examina	lon end/or inve	atigation, in	my opinion, de	eath occured at the	time, date end	place, and due to t	he cause(e	e) end menner ae stated.
ပ					-					
ᇤ	29b. SIGNATURE AND TITLE OF CERTIFIER	445				29c. LICENSE NUI				(Month, Day, Year)
160 BE	Gan Otton MD D40850 12/14/94									
T.	30. NAME AND ADDRESS OF PERSON WHO) (Type, Prin)			-	-	
Art.	YVUNNE 07	32. REGISTRAR'S SI	G.	00 0	ATOM	ALIE F	RAITI	M6015	MI	21229
	31. DATE FILED (Month, Day, Year)	2. BEGISBRAD'S CH	NATURE		17070	1106 1.	7/10/1	, -(-) - (-)	1011.	- 21269
- 11		A A A A A A A A A A A A A A A A A A A								
	DFC1 9 1994 A	COR COMPANIENT BY	-							

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THERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. requires that the death certificate be executed within fours after death. Page 6 may be retained by the hospital or attending physician. **BALTIMORE, MARYLAND 21215-0020**

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IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.								
Į.	1. DECEDENT'S NAME (First, Middle, Last) Thelma The		2. DATE OF DEATH MONTH DEC . 06	, 1994 ^e	3. TIME OF DEATH 10:45 P M				
	578-40-6961	5. SEX 6. AGE (In yrs. le. 1 \(\text{ M 2} \) F \(\text{ 8} \) 4	YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) S. Carolina			
TOR	98. FACILITY NAME (If not institution, give street Maryland General RESIDENCE OF DECEDENT	1 Hospital			imore	EATH	9c. COUNTY	OF DEATH	
FUNERAL DIRECTOR	10a. STATE 10b. COUNTY MD .		10c. CITY,	TOWN OR LOCAT	imore			10d. INSIDE CITY LIMITS? 1 NO YES 2 NO	
JERAL	2357 Eutaw Pła			10f	21217		_	OF WHAT COUNTRY?	
B	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. AI FORCES? 1 YES 2 SE IF YES, GIVE WAR OR DATES	RMED NO	It yes, spe		NIC ORIGIN? (Specify Yea in, Puerto Rican, atc.) y:	or No- 14, 1	RACE — American Indian, Black, White, atc. Specify: Black	
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade con Elementery/Secondery (0-12)	TION 18a. Di (C (F) (F) (F) (F) (F) (F) (F) (F) (F) (F)	Give kind of wo e. Do NOT use	usual occupation of done during mose retired.) d Care	N st of working	16b. KIND OF BUS	INESS/INDUST	RY	
BE CON	17. FATHER'S NAME (First, Middle, Last) George Dunham				Uule				
10 8	James R. Holm							∛D. 21217	
	20s. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Removal 4 Donation 5 Other (Specify)		AND DATE OF					or Town, State Smills, MD.	
	21. SIGNATURE OF FUNERAL SERVICE LICENS	Lector CFSP		E.L.	_	s F/H Ba	lto.,1	N.Monroe ST MD. 21217	
MMEDIATE CAUSE (Final disease or condition resulting in death) S. Patchy Bronchopneumonia Due to (or as a consequence of):							Interval Between Onset and Death Unknown 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE		
B≼	1 Natural 5 Pending 2 Accident Investigation 3 Suicida 8 Could not be	28a. PLACE OF INJURY — At he building, atc. (Specify)	oma, larm, at	M 1 🗆 Y	PRK? YES 2 NO	281. LOCATION (Street a City or Town, State)	nd Number or Ri	ural Route Number,	
COMPLETED	4 Homicide determined 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAL)	AN: To the bast of my knowledge, do	leath occurre	d at the time, data	and place, end dua		ner as stated.		
		On the basis of examination and/or				time, date and place, and	due to the car		
TO BE	9+	COMPLETED CAUSE OF DEATH (ME	M,	\sim	8922			2-06-94	
	Tatiana Mour	avskaia, M.I			land Ge	eneral Ho	spita	1	
	DEC1 9 1994 July 32 BEGATHAR'S GRATURE								

3. TIME OF DEATH

YEAR

REG. NO

2. DATE OF DEATH MONTH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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PKINS Drinnie 994 4. SOCIAL SECURITY NUMBER 5. SE 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR 7. DATE OF BIRTN (Month, Day, Year IF UNDER 24 HRS. 224-10-4624 DAYS HOURS 1 M 2 F 4 South Carolina by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should removal. 9a. FACILITY NAME (If not institution, give street and number) 96. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Baltimore City RESIDENCE OF 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore City Baltimore 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2095 Rockrose Avenue 21211 U.S.A. nours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS OECENDENT OF NISPANIC ORIGIN? (Specify Yea or No-If yea, specify Cuban, Maxican, Puerto Rican, etc.) 1 — YES 2 MD Specify: 14. RACE — American Indian, Black, Whita, atc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 2 X NO 1 Never Married 2 Married ВУ 3 Wildowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5 +) 1 Year Owner Real Estate & Rest Homes ONCE. 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) notified at Henry Burrel1 BE Lily Rollins 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Alma Davis 401 Townes Greenville, South Carolina 29601 pe 20a. METHOD OF DISPOSITION

1 M Burial 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, Stata must etery, cremetory or other place) WoodLawn Cemetery 4 Donation 5 Other (Specify) 12/18 Greenville, SC examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133 medical 23. PART i. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in by Approximate interval Between ahock, or heert failure. List only one cause on each line. n and completely filled to burtal, cremation, or IMMEDIATE CAUSE (Final Onset and Death the disease or condition andio res within event, resulting in death) DUE TO (OR AS A CONSEDUENCE OF) executed 5 cu D traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEDUENCE OF): attending physician ntal Hygiene prior to if any, leading to immediate certificate be cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events other DUE TO (OR AS A CONSEDUENCE OF): resulting in death) LAST 10 has been signed by the atte Dept. of Health and Mental Injury. PART ii. Other algnificent conditions contributing to death but not resulting in the underlying ceuse given in Part i. MEDICAL 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS WAILABLE PRIOR TO 23 shows any COMPLETION OF CAUSE 1 YES 2 ND 1 TES 2 NO PHYSICIAN: NP. 25. WAS CASE REFERRED TO MEDICAL The 26. PLACE OF DEATH (Check only one) Tem. this certificate h HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: OR ATTENDING PHYSICIAN: 1 YES 2 rme 5 - Residence 8 - Other (Specify) 0 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) marked, 286. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 TYES 70 THE FUNERAL DIRECTOR: After 7
TO THE FUNERAL DIRECTOR: After 7
De filed within 72 hours after death After t В Accident 28s. PLACE OF INJURY — At home, 1srm, street, building, atc. (Specify) 3 Sulcide 6 Could not be determined 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 4 Homicide 1 _ CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CENTURIER 290-LICENSE NUMBER 29d. DATE SIGNED (Month, Day, was 688 20146 to 223 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 50 0 d 31. DATE FILED (Month, Day, 32. REGISTRAR'S SIGNATURE DFC1 9 1994 DHMH-18 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign Country)

4:03pm

Maryland

94

9c. COUNTY OF OEATH

do

Approximate Interval Between Onset and Death 3 days

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

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2. DATE OF DEATH MONTH

7. DATE OF BIRTH (Month, Day Year) Mar. 28

12

IF UNDER 1 YEAR IF UNDER 24 HRS.

DAYS

MONTHS

	2, 3 sho	DIRECTOR	Church Hospital				Baltimore City				Y OF OEAT	Н
	it. Pages 1,		10e. STATE 10b. COUNT Maryland	Harford	10c.	CITY, TOWN (OR LOCATI	Jopp	a			d. INSIDE CITY LIMITS? YES 2 X NO
	n. ansit permit.	FUNERAL	10e. STREET AND NUMBER 323 B	lackburn Cou	rt		101.	ZIP CODE 2108	15			States
215-0020	attending prysician. se as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 X Widowed 4 Olvorced	12. WAS DECEDENT EVER FORCES? 1 X YES IF YES, GIVE WAR OR ATMY KOTE	2 NO		If yes, spe	ENDENT OF HISPANIC O ledity Cuban, Maxican, Pu 2 X NO Specify:			Black, W Specify:	American Indian, Thite, atc.
Σ.	spital or led for us	APLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) 1 2	JCATION e completed) College (1-4 or 5+)	Iffe. Do NO	it's usual of of work done of use retired.) inter	during mos	n st of working ired	16b. KIND OF	BUSINESS/INDUS	TRY	
YLA	be det	BE COMPL		alter V. Igl					nadine	Tarr		
	5 should	10	190. INFORMANT'S NAME (Type/Print) Richard V. Igle	nart Jr.				n Court J		Town, State, Zip Co		085
ORE O			20s. METHOD OF DISPOSITION 1 X Buriel 2 Cremation 3 Rer 4 Donation 6 Other (Specify)	20	PLACE AND DA	TE OF DISPOS	SITION (Nar	me of	DATE 20c	LOCATION — CH Baltimo	y or Town,	
ALT	e funeral dir examiner		21. SIGNATURE OF FUNERAL SERVICE L			22.	NAME AN	D ADDRESS OF FACILITY Harford RO	Leona		uck,	Inc.
P.O. BOX 68760,	pean destinctate be executed whim: attending physician and completely filled in by the initial Hygiene prior to burial, cremation, or removal ry, or other traumatic event, the medical	CERTIFICATION	IMMEDIATE CAUSE (Finsi disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	a	A CONSEQUENC	E OF):	nto	rction.		sepiretory arres	t,	Approximate Interval Betwee Onset and De 3 day.
5	een signed by the of Health and Me	MEDICAL	DID TOBACCO USE	c obstructi	ve pu	lm c	lise	cause given in Part	PER	AN AUTOPSY FORMED?	CO OF	ERE AUTOPSY FINDING ANLABLE PRIOR TO EMPLETION OF CAUSE F DEATH? YES 2 LING
AL	has b Dept.	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL	COMMISSIE	CAUGE	01 00		ACE OF DEATH (Check o	nly one)			
5	rtificate ne Stat	Sic	EXAMINER? t ☐ YES 2 ☑ NO	HOSPITAL:	ipetient 3 🗆 00	OTHEI	R: rsing Home	5 Residence 6 Q	Other (Specify)	HOSDI	too	
N C	his ce with th	ВУ РН	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28a. DATE OF INJURY (Month, Day, Year)		TIME OF INJURY M		RK? ES 2 NO	284. DESCRIBE HOW INJURY OCCURED			
DIVISION	23 afte 23	8	3 Suicide 6 Could not be determined	26s. PLACE OF INJUR building, stc. (Sp	IY — At home, fee	rm, street, fact	tory, office	261	LOCATION (Str City or Town, S	eet and Number or tate)	Rural Rout	a Number,
5		COMPLET		SICIAN: To the best of my kno ER: On the besis of examinati								id manner sa stated
i	TO THE FUNERAL DE filed within 72 IMPORTANT: If	TO BE	296. SIGNATURE AND TITLE OF CERTIFIE	2. Huis 1	On			29c. LICENSE NUMBER	73	29d. DATE 5	IGNED (Me	onth, Day, Year)
. 1	20		30. NAME AND ADDRESS OF PERSON WITH COMMENT OF PERSON WITH COMMENT OF PERSON OF PERSON WITH COMMENT OF PERSON OF PERSON WITH COMMENT OF PERSON OF PERSON WITH COMMENT OF PERSON OF PERSON WITH COMMENT OF PERSON OF PERSON WITH COMMENT OF PERSON WITH COMME	32. REGISTRAR'S SIG	N.16	Type, Print)	dr.	ect Bu	otina	e mic	2	1205
	165	TN	/ किस्ति ग्रह्म	Lance company	MCA	•						

TOR em#1,4 Per FINTE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

1. STATE REGISTRAR

CERTIFICATE OF DEAT!

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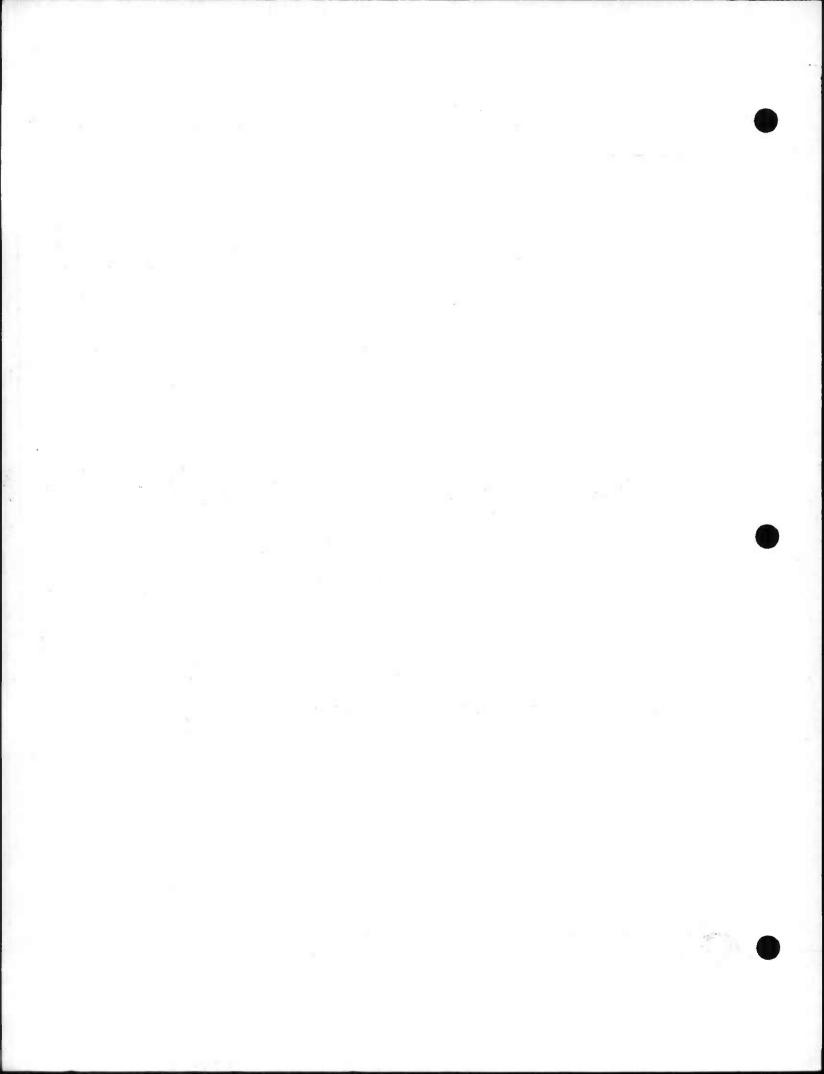
1. DECEDENT'S NAME (First, Middle, Last)

5. SEX

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4. SOCIAL SECURITY NUMBER

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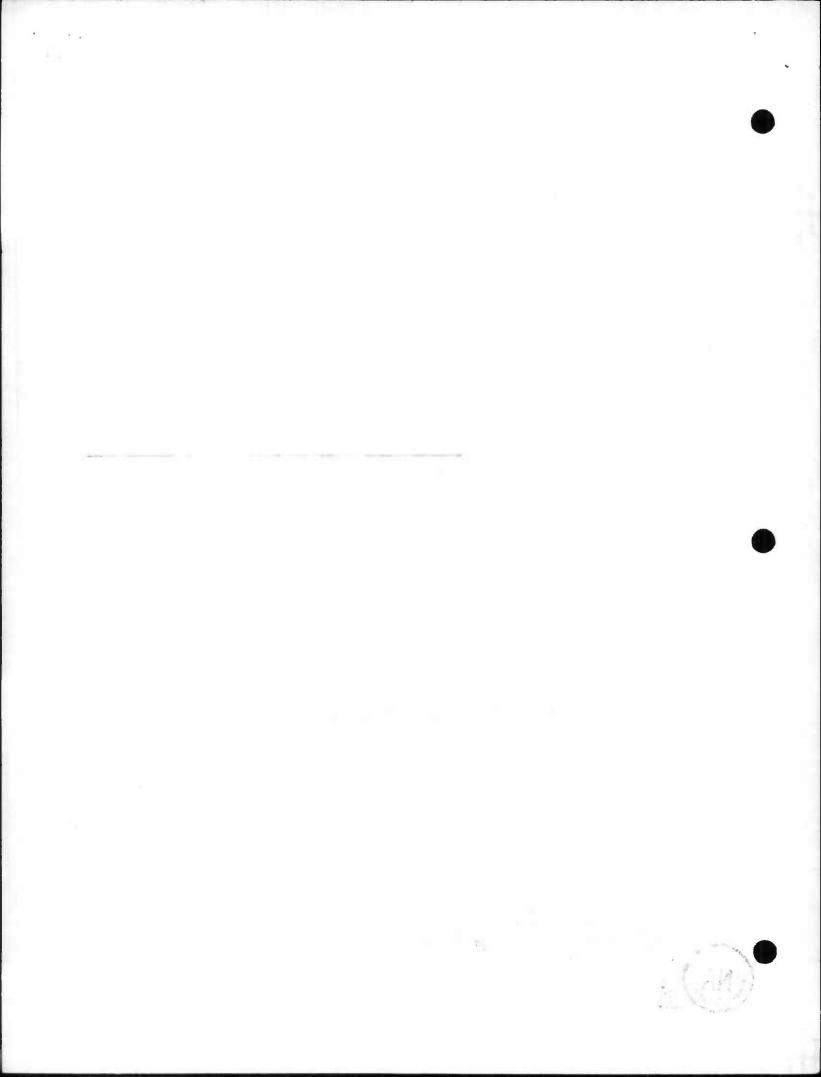


BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

ed with nours after death. Page 6 may be retained by the hospital or attending p	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the be field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with	DUIS a
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	Item # 20b ,20c Film # G 718 12-19	-94 N.A. Per	funeral h	ome		34	3/421
	1 - FOR STATE OF MAR	RYLAND / DEPART	MENT OF HE		NTAL HYGIEN	Ε	
	1. DECEDENT'S NAME (First, Middle, Last)			2.	DATE OF DEATH		3. TIME OF DEATH
	GENE CLAY JOHNSON				ec. 17, 1		7:20 AM M
	4. SOCIAL SECURITY NUMBER 5. SEX 6.				DATE OF BIRTH (Month, Day, Year)		I. BIRTHPLACE (State or Foreign Country)
1	410-58-2056 1₺ M 2 □ F	56 YRS.	ONTINS DATS A	OUTIO MINT.	t 14, 19	38 T	ennessee
	9a. FACILITY NAME (If not institution, give street and number)	•	b. CITY, TOWN OR	LOCATION OF DEATH		9c. COUNT	Y OF DEATH
DIRECTOR	5619 Manor Dr.		Woodbin	ie		Carr	oll County
E C	10a. STATE 10b. COUNTY	toc. CITY,	TOWN OR LOCATION	N			tod. INSIDE CITY
	Maryland Carroll Co.	l w	oodbine				t YES 2 NO
AL.	10e. STREET AND NUMBER			IP CODE		10g. CITIZE	EN OF WHAT COUNTRY?
FUNERAL	5619 Manor Dr.			21797		USA	
2	11. MARITAL STATUS 1 ☐ Never Married 2 ☑ Married 12. WAS DECEDENT EVER FORCES? 1 ☑			DENT OF HISPANIC C		or No-	4. RACE — American Indian, Black, White, atc.
₽	3 Widowed 4 Divorced IF YES, GIVE WAR	or dates Vietnam		NO Specify:	,		Specify: White
	15. DECEDENT'S EDUCATION	16a. DECEDENT'S US			16b. KIND OF BUS	I SINESS/INDUS	
I I	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of wor life. Do NOT use	rk done during most o retired.)	of working			
Į Ę	12th Grade	Civil Se	rvice		Federa	al Gov	ernment
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		1	6. MOTHER'S NAME (First, Middle, Malden	Sumame)	
B	Oscar Johnson			Marie N			
2	19a. INFORMANT'S NAME (Type/Print)			Number or Rural Route			(ode)
	Mrs. Kathleen Johnson			Woodbine		21797	
	1 % Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	206 PLACE AND DATE OF Pilgrims Re- Twin Cake M	st Bapt.	Cem	DATE 20c LO	esville	ty or Town, State
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	twin bake M	22. NAME AND	ADDRESS OF FACILIT	TY		
	I John V Rugna	0)		-Queen Fu			-
3	23. PART i Enter the disease, or complications that ca	used the death. Do not					eld, MD 21784
	shock, or heart fallure. List only one ceuse	on eech line.	t artor tria mode	or bying, such as	caldiec of respi	valory arres	interval Between Onset and Death
	disease or condition	endocrino	Malici	ion co			12 months
	resulting in death) e. , , , , , , , , , , , , , , , , , ,	AS A CONSEQUENCE OF):	9	-			10 1/(1/11
Z	Sequentially list conditions, b.						
ERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	AS A CONSEQUENCE OF):					
5	CAUSE (Disease or injury	AS A CONSEQUENCE OF:					
Ē	thet initiated events reaulting in death) LAST	,					İ
5 0	d						1
AL	PART II. Other aignificant conditions contributing to dea	th but not resulting in	the underlying o	ause given in Par	I. 24a. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
MEDICAL					1 🗀 YES 2	□ NO	OF DEATH?
							1 TYES 2 NO
PHYSICIAN:	DID TOBACCO USE CONTRIBUTE 25. WAS CASE REFERRED TO MEDICAL	TO CAUSE OF					
SICI	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER		OTHER:	E OF OEATH (Check of			
Ή.	27. MANNER OF DEATH 28a. DATE OF INJ	JRY 28b. TIME	OF 28c. INJUR	5 Residence 8 X	d. DESCRIBE HOW I	NJURY OCCU	RED
ВУ Р	1 Netural 5 Pending (Month, Day, Y	ear) INJUF	M 1 YES	?			
	- Indicate	JURY — At home, ferm, stre	eet, factory, office	261	LOCATION (Street a	and Number or	Rural Route Number,
	4 Homicide datarmined				Only or lown, State)		
COMPLETED	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my	knowledge, desth occurred	at the time, date an	d place, and due to t	he cause(a) and mar	nor as stated	1.
OM	one) 2 MEDICAL EXAMINER: On the basic of exami						
BE C	29b. SIGNATURE AND TITLE OF CERTIFIER		2	9c. LICENSE NUMBER		29d. DATE S	SIGNED (Month, Day, Year)
TO B	They Counts			D542511		12	118/94
F	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE O						
	Philip Konits	2059 Baltin	nore Blvd	l. Westm	inster, l	MD	
	DEC1 9 1994 Julia Studier	SIGNATURE					



BALTIMORE, MARYLAND 21215-0020	tained by the hospital or attending physician
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BALT	yours after death.
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permit. Pages 1, 2, 3 should

funeral director, page 5 should be detached for use as the burial-transit

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Item 23 shows any injury, or other traumatic event, the medical examiner

the attending physician and completely filled in by the Mental Hygiene prior to burial, cremation, or removal.

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certificate has be the State Dept.

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DIVISION OF VITAL RECORDS, P.O. BOX 68760.	The same of a service of the same requires that the death certificate he executed with
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94 37422 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH 3. TIME OF DEATH HW SUN ACK 4. SOCIAL SECURITY NUMBER 5. SEX 5. AGE (In yrs. last birthday) 7. DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. BIRTHPI ACE (State or Forming 3 1 M 2 | F 16 YRS. 9e. FACILITY NAME /# TOWN OR LOCATION OF DEATH 9b. CITY. 9c COUNTY OF DEATH DIRECTOR RESIDENC 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 10 54 as 2/2 Ш 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 2 Merr If yee, specify Cuber, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES BY 3 Wildowed 4 Divorced Skill 18e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Sn (Give kind of work done life. Do NOT use retired.) of Balto College (1-4 or 5+) nu 17. FATHER'S NAME (First, Micidia Last) 18. MOTHER'S NAME (First, Middle, Maiden Su BE 19a, INFORMANT'S NAME (Type/Print) 2 Irainia 57 21217 200 METHOD OF DISPOSITION
1 Burlet 2 Cremeflon 3 20b. PLACE AND DATE OF DISPOSITION (Name) of DATE Donetion 5 - Other (Specify) Md 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 2 rome abast 23. PART I. Inter the diseases, or complicatione that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximata hock, or heart fallure. List only one cause on each line. interval Batween Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) el DUE TO (OR S A CONSEQUENCE OF) rasho CERTIFICATION Sequentially list conditions, DUE TO (OR A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 70 1 YES 2 NO DEATH YES DID TOBACCO USE CONTRIBUTE TO PHYSICIAN: CAUSE OF NO [25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY 1 Natural 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE DF INJURY — At home, farm, street, fectory, office building, stc. (Specify)

29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. (Check only one) 2 MEDICAL EXAMINER: On the b

29b. SIGNATURE AND TITLE	Scal	19
		60"

8 Could not be

20g, LICENSE NUMBER

2-14-94 DR DARSHAN, S

28f. LOCATION (Street end Number or Rural Route Number, City or Town, State)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IXAM 27/17/10, Print)
1600 W. MOUNT ROYAL AM, I Parts 21217

31. DATE FILED (MONTH). A STEER AND SOUTH

DHMH-18 Rev 1/89

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DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	2
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	OD ATTENDING DUVOICIAM. The law requires that the death cartificate he executed within

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First, Middle, Lest) I. Johnson	n	2. DATE OF DEATH	3. TIME OF GEATH
		4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. Ia	MONTHS DAYS MOURS MAN	7. DATE OF BIRTH	BIRTHPLACE (State or Foreign Country)
pluods		90. FACILITY NAME (If not institution, give streeyend number)	9b. CITY, TOWN OR LOCATION OF D	JULY 7, 19/2	Mary land
2, 3	TOR HO	932 North Fulton arene	D #	ore	
Pages 1,	DIRECTO	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY A A	10c. CITY, TOWH OR LOCATION		10d. INSIDE CITY LIMITS?
permit. P		Mary land	Daltimore 101, ZIP CODE		1 YES 2 NO
ışı	FUNERAL	932 North Lulton Qu.	enue 218		USA
020 physician. burial-transit		11. MARITAL STATUS 1 Never Married 2 Married 12. WAS OECEDENT EVER IN U.S. AI FORCES? 1 X YES 2 FROM THE STATES IF YES, GIVE WAR OR DATES	NO if yes, specify Cuban, Mexic		14. RACE — American Indien, Black, While, etc.
	ED BY	3 Wildowed 4 Divorced WWII 1943	-1946 1 YES 2 TNO Speci		Black
NU 21215-0 hospital or attending ached for use as the	ETE	(Specify only highest grade completed) (C	ECEDENT'S USUAL OCCUPATION 3ive kind of work done during most of working 9. Do NOT use retired.	16b. KIND OF BUSINESS/I	
AND he hospitz detached once.	COMPLET	17. FATHER'S NAME (First, Midple, Last)	Electrician		Bovernment
# E E	ш	Eduard Johnson	San	ME (First, Middle, Malden Surname	ery
e retained e 5 should notified	TO B	Caroline Johnson	b. MAILING ADDRESS (Street and Number or Rural	And And Andrews Andrew	Zip Code), Ud 21217
Page 6 may be I director, page		20s. METHOD OF DISPOSITION 1 Disposition 3 Removal from State 4 Donation 5 Other (Specify)	AND DATE OF DISPOSITION (Name of peritory or other place)	2 OATE 20c LOCATION	- City, or Town, State
		21. SIGNATURE OF FUNERIAL SERVICE LICENSEE	22, NAME AND ADDRESS OF FA	CILITY LES FOR	eral Hm
	Ц	Joseph J. Ku	30 2202WN	orth are B	alto, Md
Ped Ped		23. PART VE fiter the diseases, or complications that caused the denock, or heart failure. List pnly one cause on each line	6.	•	Intarvsi Between
d within and of one of the completely filled in event, the m		IMMEDIATE CAUSE (Finel disease or condition resulting in desth)	ic Prostate	Cancer	3 Years
B 5 - 6	7	DUE TO (OR AS A CONSE	OUENCE OF):		
. 8 " 0 =	RTIFICATION	Sequentielly list conditions, if sny, leading to immediate	OUENCE OF):		
phy ne p	IFIC	Cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events OUE TO (OR AS A CONSE	QUENCE OF):		
E Hy	CERT	resulting in deeth) LAST			
by the or Injury	CAL	PART II. Other significent conditions contributing to death but not	resulting in the underlying cause givan in	Part I. 24e. WAS AN AUTOPS PERFORMEO?	AVAILABLE PRIOR TO
requires that seen signed by of Health an shows any	MEDI	TO PINISIC MICEVITA		1 🗆 YES 2 😉 🕅 O	COMPLETION DF CAUSE OF OEATH? 1 YES 2 NO
		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA		N 🗆	10 120 10 110
AN: The law ficate has b State Dept.	HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpettant 2 ER/Outpetient 3	8 Other (Specify)		
ATTENDING PHYSICIAN: The law ECTOR: After this certificate has b s after death with the State Dept.	CCURED				
NDING PHYS r death with	D BY	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be building ste (Specific)	M 1 YES 2 NO	281. LOCATION (Street and Numb	per or Rural Route Number.
OR ATTENDING F DIRECTOR: After thours after death	ETE	4 Homicide detarmined		City or Town, State)	
TAL OR A	COMPL	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, de one) 2 MEDICAL EXAMINER: On the basis of examination and/or			
	ш	29b. SIGNATURE AND TITLE OF CERTURIER	29c. LICENSE NU	MBER 29d. D	ATE SIGNEO (Month, Day, Year)
(P 8)	TO B	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITE	M D 363		
		Robert B. Shochet	2435 W Beli	jedere Ave	- Batto MD's
		31. DATE FILED (Month, Day year)			

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r attending physician. use as the bunal-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

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DIMISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21	, MARYLAND 21
TO THE HOST ALL INSTITUTION THYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or	be retained by the hospital or
TO THE FLUNERA CHECATURE ASSET MIS certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 miss and mental without the State Dept, of Health and Mental Myslene prior to burial, cremation, or removal.	je 5 should be detached for
IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	e notified at once.

	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF OEATH				
	EUGENE JONES				DEC.	5 94	3:50P M				
3	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. I	WONTHS	DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		THPLACE (State or Foreign ntry)				
	213-16-6091	1 X M 2 🗆 F	VRS.	10000 2000	09-19.	-24	MARYLAND				
H	99. FACILITY NAME (If not institution, give street end number) 90. CITY, TOWN OR LOCATION OF DEATH 90. COUNTY OF DEATH 90. COUNTY OF DEATH 90. COUNTY OF DEATH										
CT	RESIDENCE OF DECEDENT										
DIRECTOR	MARYLAND 106. COUNT	Y	10c, CITY, TOWN	OR LOCATION LITHORE			10d. INSIDE CITY LIMITS? 1 YES 2 \(\square\) NO				
3AL	10s. STREET AND NUMBER	~ A 15		10f. ZIP COOE		10g. CITIZEN OF	WHAT COUNTRY?				
FUNERAL	301 BLOOM			2/2/	7	4.51	9,				
	1 Never Merried 2 Married	12. WAS OECEDENT EVER IN U.S. A FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES	NO 13	WAS DECENDENT OF HISPA If yes, specify Cuben, Maxic	an, Puerto Ricen, etc.)	Bia	CE — American Indian, ick, White, etc.				
ВУ	3 Widowed 4 Divorced	WWII		1 YES 2 NO Speci	ny:	Spi	BLACK				
TED	15. DECEDENT'S EDU (Specify only highest grade	completed) (Give kind of work done	during most of working	16b. KIND OF BU	ISINESS/INDUSTRY					
COMPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)	te. Do NOT use retired.	0.1	C 117	co Ta:	UNGUT				
OM	17. FATHER'S NAME (First, Middle, Last)		445C/	18 MOTHER'S N	AME (First, Middle, Maider	2/14/1	MENI				
	ZSAIN J	ONES		CVA	1 FRE	FELDAL	1				
) BE	19e. INFORMANT'S NAME (Type/Print)	1	19b. MAILINO ADDRES	\$ (Street end Number or Rural	Route Number, City or To	vn, State, Zip Code)	1				
5	DELORES A	LLEN .	109-50	135 451	5.0Z0	WEPARK	N.V 11420				
	20e. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Rem	20b.PLACE	E AND DATE OF DISPO	SITION (Name of	OATE 20c. LO	OCATION — City or	Town, Stite				
	4 Donetton 5 Other (Specify)	G	ARLISON	1 FOREST	12/20 0	WING5	Mills				
	1/1000		22	NAME AND ADDRESS OF F	BROWN	CON MU	WITY FIH				
	1// 00	Meseur		266 W. No.	LTH AVE	BALTO	Md 21217				
	23. PART Erto the diseases, or ahock, or heart failure.	complications that caused the d List only one cause on each lin	leath. Do not ente na.	r tha mode of dying, su	ch aa cardiac or reap	piratory arrest,	Approximata Interval Between				
	iMMEDIATE CAUSE (Final disease or condition	14.14	. 01	orsculor A	•		Onset and Death				
	resulting in death)	DUE TO (OR AS A CONSI		overlular of	year						
_			-402.102 01 /.								
9	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSI	EOUENCE OF):								
CA	If any, leading to immediate cause. Enter UNDERLYING										
	that initiated eventa regulting in death) LAST	DUE TO (OR AS A CONSI	EOUENCE OF);								
CERTIFICATION		d									
AL	PART II. Other aignificant condition	is contributing to death but not	reaulting in the u	ndariying causa givan Ir	Part I. 24s. WAS AP		Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
PHYSICIAN: MEDIC					1 -1 -1		COMPLETION OF CAUSE DF DEATH?				
M					T TES	2.	1 TES 2 NO				
AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL				N D May	echon					
Sici	EXAMINER?	HOSPITAL: 1 Inpatient 2 ER/Outpatient	OTHE								
H	27. MANNER OF DEATH	28+. DATE OF INJURY	28b, TIME OF	28c. INJURY AT		INJURY OCCURED					
ВУ Р	Natural 5 Pending (Month, Day, Year) INJURY WORK?										
	2 Accident Investigation 3 Suicide 8 Could not be building, etc. (Specify) 28e. PLACE OF INJURY — At home, tarm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, Stets)										
ETE	4 Homicide determined				ony ar lown, oreig						
COMPLETED	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI	ICIAN: To the best of my knowledge, d	feath occurred et the	time, date end place, end du	to the cause(s) end ma	nner es stated.					
Š	2 MEDICAL EXAMINE	R: On the besis of examination and/or	r investigation, in my	opinion, death occured at the	time, date and place, a	nd due to the ceuse	(a) end menner es stated.				
BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	i, V ' ^		O . C . M		29d. DATE SIGNE	16/94				
2	Mendon 1	DEC	• 10/94								
	30. NAME AND ADDRESS OF PERSON WH		em 27) (Type, Print) Penn Sti	reet, Balt	imore, Ma	aryland	21201				
THE WAR MINIS											
k	DEC1 9 1994 Juli	32. HEGISTAN'S SIGNATURE									

ON OF WITAL RECORDS, P.O. BOX 68760,

	TO BE COMPLETED BY BUYSIONAN: MEDICAL CERTISICATION
examiner must be notified at once.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
he funeral director, page 5 should be detached for use al.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filed within 72 hough after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.
r death, Page 6 may be retained by the hospital or att	TO THE HOSPITAL OR ATTENDA CAME. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or att

IMMEDIATE CAUSE (Fined disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Adult Annually DUE TO (OR AS A CONSEQUENCE OF): Adult Annually DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): Cause. Enter UNDERLYING CAUSE (Disease or injury thet initisted events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENC										
A SOCIAL SECURITY NUMBER 1 SOLD STATE AND ALL STATE CONTROL OF	15PM									
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The street and Number 2122 Park Avenue 11. MARITAL STATUS 12. NAS OCCOMENT EVER IN U.S. A RINED FORCEST 13. WAS OCCOMENTED OF HISPANIC CHRISTIAN COUNTRY U.S. S. PART 13. NAS OCCOMENT OF HISPANIC CHRISTIAN COUNTRY U.S. S. PART 13. NAS OCC										
DECEMBER AND MARRER 2122 Park Avenue 19. 21217 19. CITIZEN OF WART COUNTRY? U. S. 11. MARTA STATUS 11. MARTA STATUS 11. MARTA STATUS 11. MARTA STATUS 11. MARTA STATUS 11. MARTA STATUS 12. WAS DECEMBER OF HISPANIC ORDIGITS (Specify Yes or No.) 14. MARTA STATUS 15. PROCESS 1 YES 2, 1/N or No. 11. PROCESS 1 YES 2, 1/N or No. 11. PROCESS 1 YES 2, 1/N or No. 11. PROCESS 1 YES 2, 1/N or No. 11. PROCESS 1 YES 2, 1/N or No. 11. PROCESS 1 YES 2, 1/N or No. 11. PROCESS 1 YES 2, 1/N or No. 11. PROCESS 1 YES 2, 1/N or No. 11. PROCESS 1 YES 2, 1/N or No. 11. PROCESS 1 YES 2, 1/N or No. 1/N or No	\$?									
Socional Content Press C										
TO SOUTH ALL The INFORMANT'S NAME ("TypePrint) Marjorie Purvey 100 Purvey 200 Place and Date of Disposition in the Companies of the Compan										
TO SOUTH ALL The INFORMANT'S NAME ("TypePrint) Marjorie Purvey 100 Purvey 200 Place and Date of Disposition in the Companies of the Compan										
The first continue of the place of the pla										
Approximation CFSP #281 E.L. Phillips F/H Balto., MD. 21217										
23. PART I. Enter the diseasea, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Fine) IMMEDIATE CAUSE (Fine) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury their initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): 24a. WAS AN AUTOPSY FINE ANALABLE PRIOR TO COMPLETION OF CAO OF DEATH? 1 YES 2 MAS CASE REFERRED TO MEDICAL 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only onle) 27. MAININER OF DEATH 1 YES 2 NO 28b. DITHER: 27c. MAININER OF DEATH 27c. MAINING OF DEATH 27c. MAINING OF DEATH 27c. MAINING OF DEATH 27c. MAINING OF DEATH 27c. MAINING OF DEATH 27c. MAINING OF DEATH 27c. MAINING OF DEATH 27c. MAINING OF DEATH 27c. MAINING OF DEATH 27c. MAINING OF DEATH 27c. MAINING OF DEATH 27c. MAINING	MD.									
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PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events b. Adult Nonuctory duties DUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
2 Accident Investigation M 1 YES 2 NO	PRIOR TO									
2 Accident Investigation M 1 YES 2 NO	1 Tes 2 The									
2 Accident Investigation M 1 YES 2 NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER:									
	2 Accident 3 Suicide 8 Could not be 28s. PLACE OF INJURY — At home, tarm, street, factory, office building, etc. (Specify)									
3 Suicide 8 Could not be detarmined building, etc. (Specify) 29s. LOCATION (Street and Number or Rural Route Number, City or Yown, State) 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.	or on stated.									
296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) 296. 297	Year)									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) LIVALUE A. JOHN MODEL CUTA BULLINGE MI 212/5 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE	15									
DEC1 9 1994 Juli Minden Robert	IMH-16 Rev 1/89									

DIWISTON OF VITAL RECORDS, P.O. BOX 68760

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TO THE HOSPITA OR INTENDING PAYSICIAN: The law requires that the death certificate be executed with Thours after death. Page 6 may be retained by the hos	TO THE FUNERAL MEDIUM AND THE commission been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to the complete of	The men within 12 is the marked, or team 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ertificate be	ng physician	other traur
the death co	y the attendi	injury, or
requires that	een signed b	shows any
E. The law	cate has b	item 23
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TIME PARS	Anythis	marked,
Æ	No.	00
OH AP		item 2
TO THE HOSPITA	TO THE FUNERAL	IMPORTANT: II

30. NAME AND ADDRESS OF PERSON
AMATUU A
31. DATE FILED (Month, Day, Year)
DEC1 9 1994

											74	J	1420
	1 - FOR STATE REGISTRAR	STATE OF	MARYLAND /	DEPAR ERTIF					MENTA	L HYGIEN REG. NO.	Ε		
	1. DECEDENT'S NAME (First, Middle, Last)				_				2. DATE	OF DEATH	N.	YEAR	3. TIME OF DEATH
	ILENE C. JEF	FRIES			_				12		5 19	794	8-20 AM
1	4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. las	st birthday)	IF UNDE	DAYS	IF UNDER	24 HRS.	7. DATE	OF BIRTH		8. BIRTI	HPLACE (State or Foreign
	212-80-3641	t ☐ M 2 🔀 F	36	YRS.	MONTHS	DAYS	HOURS	MIN.		06/19	57		LTIMORE
	9e. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH												
l o l	NORTHWEST N/H BALTIMORE												
DIRECTOR	RESIDENCE OF DECEDENT 100, STATE 10b, COUNTY	,		I son CIT	V TOWN	OR LOCAT	1011						
I E													10d. INSIDE CITY LIMITS?
	MD. 100. STREET AND NUMBER			BA	L'I.TI	MORE	ZIP CODE	-					1X YES 2 NO
FUNERAL	3313 WOODLAND	AVE				101		121	5		10g. CI1	US.	WHAT COUNTRY?
N I	11. MARITAL STATUS		T EVER IN U.S. AF	MED	1 40	WEG DEG				17 (Specify Yes			
	1 🔀 Never Merried 2 🔲 Merried		YES 21		13.	If yes, sp	ecify Cuba	n, Mexice	in, Puerto I	Rican, etc.)	or No-	Blac	E — American Indian, k, White, atc.
B	3 Wildowed 4 Divorced	IF YES, GIVE	MAR OR DATES			1 YES	2 XNO	Specify	y:			Spec	BLACK
유	15. DECEDENT'S EDU	CATION	16a, OE	ECEDENT'S	USUAL C	CCUPATIO	ON		16b	KIND OF BUS	SINESS/IN	DUSTRY	DENIGH
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5	+) (G	ive kind of Do NOT u	work done se retired.)	during mo	st of working	g					
릴	12th			URS	TNG	ASS	TST						
Į į	17. FATHER'S NAME (First, Middle, Last)								ME (First, I	Middle, Maiden	Sumame)		
ш	ABRAHAM JEFFRI	ES					TH	ELM	A WE	BB			
8	19e. INFORMANT'S NAME (Type/Print)									ber, City or Town		p Code)	
PN	THELMA JEFFRI	ES	2	2656	PR]	ESBU	JRY	ST.	BAL	TO. N	ID.	212	16
1 1	20a. METHOD OF DISPOSITION 1 Street Burlet 2 Cremation 3 Rem	ound form Chate	20b.PLACE				me of		DAT	E 20c. LO	CATION -	City or To	own, State
	4 Donellon 5 Other (Specify)	Over LIGHT 2016	KINGS	ME	MOR	IAL	12	-20	-94	RAN	IDAL	STO	WN, MD.
1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE /	5-00		22.	NAME AN	D ADDRE	SS OF FA	CILITY				
	· ////	11/1/	-	_						E F?	PA		
\vdash	23. PART I. Enter the diseases, or o	omplications the	it caused the de	eath. Do i	not ente	538	N de of dy	GILI	MOR	ST 7	2121	7	Approximate
	shock, or heart fallura.	List only one ca	usa on each line	n.	iot omo	1 (110 1110	de or dy	rry, auc	ir ee cerc	nec or reapi	ratory at	reat,	Interval Between
1 1	IMMEDIATE CAUSE (Final disease or condition	50		00	11 /	3	- 01 -			PI	avi	100 1	Onset and Death
	reaulting in death)	- 24 49 DUE TO	LOR AS A CONSE	OHENCE	11	_91	Cill	OTT	9		977	117 X	145
_	IMMEDIATE CAUSE (Final disease or condition resulting in death) Squamous Cell Carcinoma of Larynx 14r Due to (or as a consequence of): Sequentially list conditions. Sequentially list conditions.												
ERTIFICATION	Sequantially list conditions, Due to (or as a consequence of): Due to (or as a consequence of):												
¥	cause. Enter UNDERLYING												
트	CAUSE (Disease or Injury that initiated events	c. DUE TO	(OR AS A CONSE	OUENCE O	F):								
토	reaulting in death) LAST	d.											
0	PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? AMAILABLE PRIOR TO												
🕺									. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO				
ă									OF DEATH?				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO								1 TES 2 NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 26. PLACE OF DEATH (Check only one) 26. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 26. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 26. Was CASE REFERRED TO MEDICAL 1 Inpatient 2 26. PLACE OF DEATH (Check only one) 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 280. DATE OF INJURY 280. INTURY OF INJURY AT WORK? 260. DESCRIBE HOW INJURY OCCURED 260. DESCRIBE HOW INJURY OC													
B	1 M 1 Course Course												
	3 Suicide 6 Could not be 4 Homicide determined	28e, PLACE (OF INJURY — At he , atc. (Specify)	ome, ferm,	streel, fac	ctory, office	•			ATION (Street a or Town, State)	ind Numbe	r or Rural	Route Number,
COMPLETED	290. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best o	f my knowledge, de	esth occurr	ed at the	time, date	end place	end due	to the cau	se(s) end men	ner ee sta	rted.	
ō	000) 2 MEDICAL EXAMINE	R: On the basis of s	xamination end/or	Investigation	on, In my	opinion, d	eath occur	ed at the	time, date	end place, en	d due to t	he ceuse(s) end manner ee stated,
ш	29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICE	NSE NU	MBER		29d. DA	TE SIGNED	(Month, Day, Year)
00	Amatun 4 1	lacem	M.D				D	15	50	3	D /	2/1	6/1994
2	30 NAME AND ADDRESS OF REPSON WA	O COMPLETED CALL	SE OF DEATH /ITE	MAD CI-	D-l-st					- /	_		-/

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

NAFEM, 501 Dolphin Street,

32, REGISTRAR'S SIGNATURE

1 - FOR STATE REGISTRAR

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SION OF	1
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	1. DECEDENT'S NAME (First, Middle, Lest) JOHN				KJ	CZU	JLA	2. DATE OF MONTH DEC.	DEATH DA	199	3. 4 8	:40	PEATH A
	4, SOCIAL SECURITY NUMBER 213-70-4012	rs. last birthday) YRS.	IF UNDE	DAYS	04 P				Engla				
стов	90. FACILITY NAME (If not institution, give s JOHNS HOPKINS-		HOS	PITAL			OR LOCATION OF D			9c. COUNTY	OF DEAT	н	
DIREC	nesidence of decedent 100, STATE 100, COUNT Maryland	Baltim	ore	10c, CIT	Y, TOWN	OR LOCA	TION Dund	alk	-			d. INSIDE (
AL.	100. STREET AND NUMBER 1949 Inverton Ro				10f. ZIP CODE 21 222					10g. CITIZEN		T COUNTR	
BY FUNER	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 IF YES, GIVE W	YES 2	SUNO.		If yee, s	CENDENT OF HISPA pecify Cuben, Mexico S 2000 Specifi	n, Puerto Rice		or No — 14.	RACE — Black, W Specify:	American inte, atc.	
PLETED	15. DECEDENT'S EDU (Specify only highest grade Elamentary/Secondary (0-12)	College (1-4 or 5+		life. Do NOT u	work done sa retired.)	during m	ON ost of working			INESS/INDUS	TRY		
TO BE COMPLI	17. FATHER'S NAME (First, Middle, Last) Michael Kiczula	2 Years		Macri	Machinist Aerospace 16. MOTHER'S NAME (First, Middle, Malden Surname) Edna Birley								
	190. INFORMANT'S NAME (Type/Print) Mary Ann Plummer	<u>-</u>				end Number or Rural on Place	Route Number,			2116	2		
	20e METHOD OF DISPOSITION **Burlel 2 Cremetion 3 Rem 4 Donetion 5 Other (Specify) 21. SIGNATURE OF MINERAL SERVICE LIK	CEAND DATE OF DISPOSITION (Name of Lighter piece) A Commetory of other piece) LIV Hill Mem. Pk. 12/19/94 Middle Rive											
	Stregan	E Keen	9			Duda 7922	nd address of fa 1—Ruck Fu 2 Wise Av	neral e. Du	ndall	c, MD	212	•	nc.
	23. PART I. Enter by diseases, or shock, of heart fallura. IMMEDIATE CAUSE (Finst disease or condition resulting in death)	a. Albert	oscl	ilina.	4								kimate il Betweer and Deeti
ERTIFICATION	Sequentially list conditions, If sry, leading to immediate csuse. Enter UNDERLYING CAUSE (Disesse or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): C. OUE TO (OR AS A CONSEQUENCE OF):												
MEDICAL CI	PERFORMED? 1 FES 2 NO CC											MPLETION (DEATH?	OF CAUSE
SICIAN: N	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL EXAMINER?	RIBUTE TO CAL		PLACE OF DEA		only one)		N D			1 15	ES 2	
BY PHYS	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	1 Inpatient 2 28e. DATE OF I	INJURY	28b. TIM	4 🗌 Nur	28c. IN.	JURY AT DRK? YES 2 NO			JURY OCCUR	ED		
ETED B	3 Suicide 8 Could not be determined	28e. PLACE OF building, a	INJURY — I	At home, term, i	itreet, fec	tory, offic	:0	281, LOCATIO City or To	N (Street ar wn, State)	nd Number or F	Rural Route	Number	
COMPL		CIAN: To the bast of r									euse(s) and	d manner (se stated.
TO BE	296. SIGNATURE AND THE OF CERTUPIES 30. NAME AND ADDRESS OF PERSON WH	9º Co	7				O.C.M.			29d. OATE SI		nth, Day Ye	
	David R F	COMPLETED CAUSE	. 11	1 Pen		tre	et, Bal	timor	e. M	aryla	and	212	01
	DECT 2 1984 %											Dian	H-16 Rev

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with a nours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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It	em # 7 Film # G 718 12-	19-94 N.A. Per	Funeral	home			94	37428		
	1 - FOR STATE REGISTRAR	STATE OF MARYLAN			HEALTH AND F DEATH	MENTAL HYGIEN REG. NO				
	1. DECEDENT'S NAME (First, Middle, Last) AUGUSTA	DOPOTHY	RA	Ш		2. DATE OF DEATH	AY TYPEAR	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 046-12-7072	5. SEX 8. AGE (In)	yrs. lest birthdey) YRS.	IF UNDER 1 YEAR MONTHS DAY		7. DATE OF BIRTH 97 (Month, Day, Year)	THPLACE (State or Foreign intry) W York			
OR	99. FACILITY NAME (If not institution, give st 6911 Fitzpatrick RESIDENCE OF DECEDENT	Control of the Contro		96. CITY, TOW Laur	EATH	9c. COUNTY OF P.G.	DEATH			
DIRECTOR	10n. STATE 10b. COUNTY Maryland P.G.		10c. CIT	Y, TOWN OR LO			10d. INSIDE CITY LIMITS?			
	10e. STREET AND NUMBER			Laurel	10f. ZIP CODE			1 ☐ YES 2 💢 NO F WHAT COUNTRY?		
BY FUNERAL	6911 Fitzpatrick 11. MARITAL STATUS 1 Never Married 2 Married 3 🖔 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE	2 X NO	If yes,	20707 DECENDENT OF HISPA specify Cuban, Maxic (ES 2 X NO Speci	NIC ORIGIN? (Specify Yearn, Puerto Ricen, etc.)	Bla Sp	CE — American Indian, ack, White, etc.		
COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12) 1 0 t h	CATION completed) College (1-4 or 5+)	6n. DECEDENT'S (Give kind of life. Do NOT us	work done during	ATION most of working	Mfg.	SINESS/INDUSTRY			
ш	17. FATHER'S NAME (First, Middle, Last) Adolph Schott					AME (First, Middle, Melden Alice Sch				
TO B	190. INFORMANT'S NAME (Typo/Prim) Arlene Rogozinski		1000			Aoute Number, City or Towne, Laurel,		nd 20707		
	20a. METHOD OF DISPOSITION 1	oval from State 20b.Pl	LACEAND DATE	of disposition	(Name of 1 Gardens	DATE 20c. LC	rence, S			
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		Flec		Home, Inc		yland 20707		
	23. PART I. Enter the diseases, or cahock, or haert failure. IMMEDIATE CAUSE (Final disease or condition resulting in death)	complications that caused to	h line.	not enter the	mode of dylng, aud	th as cardlec or reap	Iratory arreat,	Approximate Interval Between Onset and Death		
RTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
CERT		d								
I: MEDICAL	PART II. Other algolficant condition	s contributing to deeth but	not resulting	In the underly	ring cause given in	Part I. 24a. WAS AN PERFOI	RMED?	4b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO		
SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		OTHER:	PLACE OF DEATH (C	heck only one)				
PHY	1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending	1 Inpatient 2 ER/Outpati 28a. DATE OF INJURY (Month, Day, Year)	INJURY OCCURED							
red BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28a. PLACE OF INJURY — building, atc. (Specify,	At home, tarm,		YES 2 NO	281. LOCATION (Street City or Town, State	and Number or Rura	al Route Number,		
MPLET	1000	CIAN: To the best of my knowled								
BE CO	29b. SIGNATURE AND TITLE OF CERTIFIER		1.4		29c LICENSE NU			ED (Month, Day, Year)		

DHMH-18 Rev 1/89

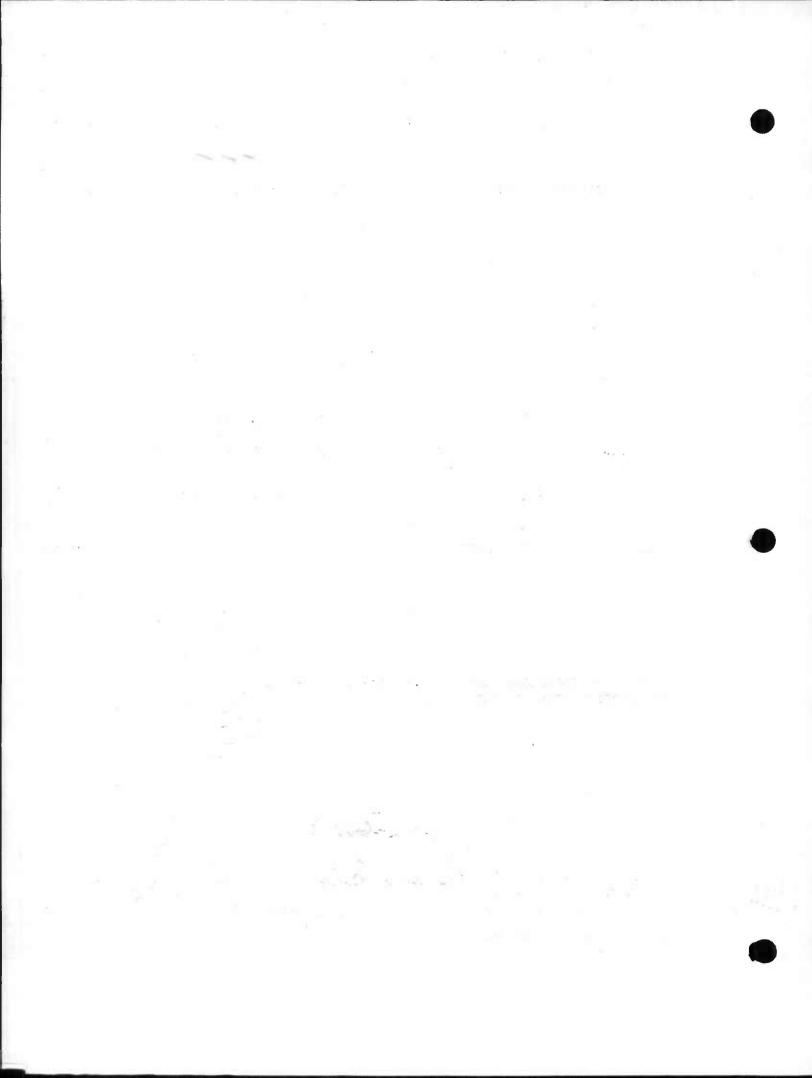
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remonal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760, IDSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with

1	-	STATE REGISTRAR	
	_		

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

	REGISTRAR		CE	RTIF	CATE O	F DEATH	REG	NO.			
	1. DECEDENT'S NAME (First, Middle, Last) JOHN Chr	istian		KESS			2. DATE OF DEA	DAY	YEAR	3. TIME OF DEATH	
- 1	4. SOCIAL SECURITY NUMBER		GE (In yrs. last					15 199		10:45 pm M	
	217-03-4807	1 🕅 M 2 🗆 F	85 85		MONTHS DAYS		7. DATE OF BIRT (Month, Day, Ye 9-21-09	09	Count	HPLACE (State or Foreign try) hington D.C	
	9a. FACILITY NAME (If not institution, give				9b. CITY, TOW	UNTY OF					
2	Saint Joseph Med	ical Center			To	wson, Man	riand		Balti	more	
E E	10a. STATE 10b. COUNT	TY		10c. CITY	TOWN OR LO	CATION				10d. INSIDE CITY	
腊	Maryland			Ba	LIMITS?						
占	10e. STREET AND NUMBER					101. ZIP CODE	_	10g. Cl	TIZEN OF	WHAT COUNTRY?	
FUNERAL DIRECTOR	3052 Mayfield	Avenue				21213			U.S	.A.	
ا څ	11. MARITAL STATUS	12. WAS DECEDENT, EVE FORCES? 1 X Y	ER IN U.S. ARI	MED	13. WAS D	ECENDENT OF HISPAI	NIC ORIGIN? (Speci	fy Yas or No-	14. RAC	E — American Indian,	
COMPLETED BY	1 Never Merried 2 Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR O	R DATES		1 - Y	specify Cuban, Mexica ES 2 NO Specif	y:	c.)	Spec		
	15. DECEDENT'S EDU (Specify only highest grade		18a. DEC	CEDENT'S U	SUAL OCCUPA	TION most of working	16b. KIND O	F BUSINESS/IN	IDUSTRY		
9	Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Do NOT use	retired.)						
MP	10			Res	tauran	t Worker		staura	nt		
	17. FATHER'S NAME (First, Middle, Last)	0.01					ME (First, Middle, M				
8	John C. Kes	sei			:		ric Wolf				
၉	C. William John	กรดท	196			t and Number or Aural Trail R				0.6	
			001 81 105 1		FDISPOSITION			C. LOCATION -			
	20e, METHOD OF DISPOSITION 1	noval from Stata	cemetery, cren	natory or oth	Luth.	Com 1	2+19-94				
	21. SIGNATURE OF FUNERAL SERVICE LI		T. 7a	VOVn	22. NAME	AND ADDRESS OF FA	CILITY		0. M	u.	
į	Leonard J. Ruck, Inc.										
\dashv	22 PART Enter the diseases or				530	5 Harford	d Road B	alto. 1	<u>1d. 2</u>		
- 1	23. PART I. Enter the disesses, or shock, or heert fellure.	List Dniy Dne ceuse D	n each lina.	nn. Do no	of enter the r	node of dying, suc	h ss cerdisc or	respiratory s	rrest,	Approximats Interval Between	
	IMMEDIATE CAUSE (Fine) disease or condition										
- 1	resulting in death) a. LEFT LOWER LOBE PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF):										
_ 1											
<u> </u>	Sequentially list conditions, If any, leading to immediate										
3	ceuse. Enter UNDERLYING	c.		1.000000000000							
	CAUSE (Disease or injury that initiated events		AS A CONSEO	UENCE OF)							
CERTIFICATION	resulting in death) LAST	d									
	PART ii. Other significant condition	ns contributing to dest	th but not re	euitina ir	the underly	ing cause given in	Part i 24a Wi	AS AN AUTOPSY	241	b. WERE AUTOPSY FINDINGS	
SAL	PULMONARY EMB						PE	RFORMED?	1	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
D D	RECURRENT ASPI			MOU	JUAN A	CUENI	¹ □ Y	ES 2 NO		OF DEATH?	
2	TIEGORINE NU ASEI	TATION FINED	VICINIA				-			1 TYES 2 NO	
4	25. WAS CASE REFERRED TO MEDICAL				28.	PLACE OF DEATH (Ch	eck anly one)				
PHYSICIAN:	EXAMINER?	HOSPITAL:	Outpatient 3		OTHER:	ome 5 🗆 Residenca	8 Other (Specific	d			
Ē	27. MANNER OF DEATH	28a. DATE OF INJU		28b. TIME	OF 28c. I	NJURY AT	28d. DESCRIBE H		CCURED		
	Natural 5 Pending	(Month, Day, Ye	ur)	INJU		YORK?					
2 Accident investigation								er or Rurai	Route Number,		
IED	4 Homicide determined	Sanding, etc. (opeony				City or Town,	State)			
COMPLET	29a. CERTIFIER 1 CERTIFYING PHYS	SICIAN: To the best of my to	nowledge, des	th occurred	d at the time, d	ita and pleca, end dua	to the cause(s) an	d manner as at	sted.		
2		ER: On the besis of examin								e) end menner se stated.	
	29b. SIGNATURE AND TITLE OF CERTIFIE					29c. LICENSE NUI				D (Month, Day, Year)	
4	Jagindur	r meh	Ca r	n.17			xx1529	> 1	2.	15.01.	
2		O COMPLETED CAUSE OF				D 41410		,	a.	13 79,	
	JOGINDER P. MEH	TA, MD ST. J	OSEPH	MED	ICAL CE	NTER TOW	SON,MD	21204			
	DEC 1 9 1994	Lis Dancher Le									
	DEC 1 9 1994 1	ma animanas in	votally								



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3.	ear) with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	m-ked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Ybar)
DEC1 9 1994

Wolfe St.

32. REGISTRAR'S SIGNATURE

DEWOLST PARTIELL

Baltmore

	FOR						-10-						
	1 - STATE REGISTRAR	STATE OF M.					EALTH DEAT		MENTA				
Ĭ	1. DECEDENT'S NAME (First, Middle, Last)			111111	ICA I		DEA	п	2. DATE	REG. NO			3, TIME OF DEATH
	DAVID B.	KINDE	D						DEC	'H D.		YEAR	01·10 AM
	4, SOCIAL SECURITY NUMBER		6. AGE (In yrs. last	t birthday)	IF UNDE	R 1 YEAR	IF UNDER	24 HRS.	7 DATE	OF BIRTH		6 BIRTI	MDI ACE (State or Engine
3	217 50 9342 9a. FACILITY NAME (If not institution, give str	1 💢 M 2 🗆 F	30	YRS.	MONTHS	DAYS	HOURS		larc	n 14		4 Count	Waryland
OB	THE JOHNS HOPKI		TAL	BALTIMORE CITY							9c. COU	INTY OF D	DEATH
2	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY			10c. CIT	Y TOWN	OR LOCAT	ION				10d, INSIDE CITY		
DIRECTOR		imore C	ity	10c. CITY, TOWN OR LOCATION Baltimore							LIMITS?		
FUNERAL	100. STREET AND NUMBER 2227 Lake Ave.					101	ZIP CODE	: 213					States
B	11 MARITAL STATUS 1 Merried 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	YES 2 N		Il yes, spi	ENDENT O	n, Maxica	n, Puerto	N? (Specify Yea Rican, atc.)	or No-	Blac	E — American Indian, k, White, atc. White	
8	15. DECEDENT'S EDUC. (Specify only highest grade of	ATION	16a. DE	CEDENT'S	USUAL O	CCUPATIO	N .		16b	. KIND OF BUS	SINESS/IN	DUSTRY	
COMPLETED	Elementary/Secondary (0-12)	College (1-4 or 5+)	(Gr life.	Dri Do NOT us		during mo.	st of workin	g	Bus Company				
O	17. FATHER'S NAME (First, Middle, Last)						18. MOTH	ER'S NA	ME (First,	Middle, Maiden	Surname)		
BE C	Leonard 19a. INFORMANT'S NAME (Type/Print)	W.											Wirth
2	John W. Thorne								LMOre			213	
	20a. METHOD OF DISPOSITION 1 Green Burles 2 Comments Green Comments Comments Green	val Irom State	20b. PLACE A	nd DATE	of bispos	Cre	me of	orv	12/	E 20c. LO	CATION —	City or To	imore, MD
	21. SIGNATURA OF PUHERAL SERVICE VICE	hinan			227	NAME AN	F.A	S OF EA	te ph	nen D	. Lo	hrma	ann 21286 alt. MD
	23. PART I. Entar the diseases, price	omplications that	caused the de	ath. Do r	not anter	tha mo	da of dyl	ng, sucl	h as care	dlac or respi	ratory ar	reat,	Approximata
	ahock, or heart fallure. L IMMEDIATE CAUSE (Finel disease or condition											Onset and Death	
	resulting in death) a	DUE TO (OR AS A CONSEQUENCE OF):										Z needos	
NOL	Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS A CONSEQUENCE OF):										Tyeurs	
CERTIFICATION	cause. Entar UNDERLYtNG CAUSE (Disease or Injury that initiated events	DUE TO (C	OR AS A CONSEC	UENCE OF	F):								
CERT	resulting in death) LAST	•											
A.	PART II. Other significant conditions	contributing to d	leath but not re	sulting	n the ur	nderiying	cause g	lven in	Part I.	24a. WAS AN PERFOR		24b	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
EDIC	Cadomyoputhy								-	1 TYES 2			COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDICAL	DID TOBACCO USE CONTR	IBUTE TO CAL	JSE OF DEAT	TH YE	s 🗆	NO [UNC	ERTAIN	- l				1 TYES 2 NO
CIA	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	26. PLAC	E OF DEAT									
YS.		impatiant 2	ER/Outpetient 3	□ DOA	4 Nur		• 5 □ Ra	aldence	6 🗆 Othe	r (Specify)			
	27. MANNER OF DEATH Natural 5 Pending Natural Investigation	28a. DATE OF II (Month, Day		26b. TIM INJ	E OF URY M	28c. INJI WO 1 Y	URY AT RK? 'ES 2	NO	26d. DES	ESCRIBE HOW INJURY OCCURED			
TED BY	2 Accident Investigation 3 Suicide 6 Could not be detarmined	26a. PLACE OF building, at	INJURY — At hor tc. (Specify)	ne, farm, s	street, lac	tory, office	1			CATION (Street of Town, State)	and Numbe	r or Rumil i	Route Number,
COMPLETED	29a. CERTIFIER Check only one) CERTIFYING PHYSIC MEDICAL EXAMINER	CIAN: To the best of m											s) and manner as stated.
BE CC	29b. SIGNATURE AND TITLE OF STRIFFER	11		1.0			29c. LICE			-0.0.			(Month, Day, Year)
6	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE	V	(An	0.111		L	165	7		▶ /2	2/15	194

2/205

all of the second of the secon

-		1 - STATE REGISTRAR		SIAIL OI I	WATTE	CE	RTIF	ICATE	OF	DEA	TH	AIEN IA	REG. NO				
		1. DECEDENT'S NAME (First		AYAYE				*******	MIDD	3.7		MON		AY	YEAR	3. TIME OF DE	
		ROBIN 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 5. SOCIAL SECURITY NUMBER 6. SOCIAL SECU		NNE 5. sex	6. AGE	(In yrs. last b	irthday)	KEN!		Y IF UNDE	D 24 MDS	DEC 16		б	94	1:26	Рм
		317-74-4708		1 M 2 X F		35	YRS.	MONTHS	DAYS	HOURS	MIN.	(Mon	th, Day, Year)	1959	Country		roreign
plnous		9e. FACILITY NAME (If not in	nstitution, give s	treet and number))		9b. CITY,	TOWN C	OR LOCATI	ION OF DE		23, .		TY OF DE		
2, 3	DIRECTOR	SUBURBAN	HOSPI	TAL				BE'	THE	SDA				MON	TGO	MERY	
Jes 1,	EC	10a, STATE	10b. COUNT	Υ			10c. CIT	Y, TOWN O	R LOCAT	ION					- T	10d. INSIDE C	ITY
permit. Pages		Washington	Ben	ton		Richland										LIMITS?	□ NO
Der.	3AL	10e. STREET AND NUMBER							1110	ZIP COO				10g. CITIZEN OF WHAT COUNTRY?			7
020 physician. bunal-transit	FUNERAL	2000 Steve	en Dr.					1		9935					USA		
020 physician bunal-tra		1 Never Merried 2	Married	12. WAS DECEDEN FORCES? 1 IF YES, GIVE V	YES	2 X NO		1	f yes, spi	ecity Cubi		n, Puerto	N? (Specify Yes Rican, etc.)	or No-	Black,	 Amarican Ir White, etc. 	ndien,
215-0 attending se as the	Э ВУ	3 Widowed 4 Divo	orced	11 123, 0112		AIES		_ '		2 <u>M</u> NO	ърест) 	/: 			Specify	Whi	te
n atte	Ë	(Specify onl	EDENT'S EDU y highest grade			(Give	kind of v	USUAL OC work done of se retired.)	CUPATIO	ON st of worki	ng	16	b. KIND OF BUS	SINESS/IND	USTRY		
D 2	PLE	Elementary/Secondary (0)-12)	College (1-4 or 5-	+)	Comp			l o c	Pon			Comput	or TN	duct	2017	
AND 21 the hospital or detached for u	COMPLETED	17. FATHER'S NAME (First, M	liddle, Last)	1 year		ГСОШР	ure.	L bal	Les		HER'S NA	ME (First,	Middle, Maiden		dust	Ly	
d by t	BE C	John Bayer								G	era1	dine	Payme	nt			
MAR retained to 5 should notified	2	19a, INFORMANT'S NAME (1											nber, City or Tow		Code)		
RE, n may be o or, page 5 st be n		Mr. John Bay			201	58 b. PLACE ANI					Av		ake, 0		4012		
ALTIMORE, death. Page 6 may be funeral director, page		1 X Burtal 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 🗆 Ram	oval from State	cen	metery, crema	tory or o	ther plece)			lan	12-		cation -6		n, State	
ALTIM death. Page funeral dire		21. SIGNATURE OF FUNERA		CENSEE	TIVE	2 ()	22.1	NAME AN	ID ADDRE	SS OF FA	CILITY					
		John	n K	Ayn	rol	2)	1						ral Di: Randal				2.2
c at		23. PART . Enter the d	iseases, or o	omplications the	t cauead	d the deat	h. Do n	not entar	tha mo	de of dy	ing, auci	h aa ca	diac or reapi	ratory arro	eat,	Approxi	imate
		IMMEDIATE CAUSE (Fir		ciat only one cat	Jaa Ori a	racii iiria.											Batwean and Death
= 3 th		disease or condition resulting in death)	→	a. FATTY L		A CONSEQUI											
P 2 2 - 6	_				(On AS A	A CONSECUI	ENCE OF	-);									
OX 68 e be execute sician and co prior to buria traumatic	RTIFICATION	Sequantially list conditi if any, landing to imme	diata	DUE TO	(OR AS A	A CONSEQUI	ENCE OF	7):									
O. BO. ertificate be ing physicial giene prior other trau	ICA	cause. Entar UNDERLY CAUSE (Disease or inju		c.	(OD AS A	A CONSEQUI	ENCE OF		_								
V. 5 5 5 P	E	that initiated eventa resulting in death) LAS	т .	4	(011 25 2	A CONSECUT	LIVE OF	,.								İ	
DS, P the death the atten d Mental I injury, o	핑	PART II. Other aignifica	et condition	e contribution to	death h	nut not ma	ulala a I	in the sec	ele electere		No.					1	+4 2003
K 8 5 8 7	DICAL	PART II. Other algrinica	rit condition	a contributing to	death b	out not rea	uiting	in the un	darlying	g cause (given in	Part I.	24s. WAS AN PERFOR	MED?		WERE AUTOPSY AVAILABLE PRIC COMPLETION O	OR TO
RECO requires th een signed of Health shows an	MED											_	1 PYES 2	□ NO		OF DEATH?	
		DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE O	OF DEATH	H YE	S 🗆 N	10 🗆	UNC	ERTAIN	۷ D				YES 2	J WO
4 0 E -	SICIAN:	25. WAS CASE REFERRED TO EXAMINER?		HOSPITAL:		26. PLACE		H (Check o	only one)								
VIT, CIAN: Th ertificate the State	HYSI	1- YES 2 NO		1 Inpatient 25			_			• 5 □ Ra	aldence	6 🗆 Oth	er (Specify)				
NO PHYSICIAN: The this certifical auth with the Stammarked, or it	<u>م</u> ا		Pending	28a. DATE OF (Month, D		2	8b. TIMI INJ	E OF URY M		URY AT RK? (ES 2	_ NO	28d. DE	SCRIBE HOW II	NJURY OCC	URED		
After death	B _Y	2 Sulate	Investigation	28e. PLACE O	F INJURY	/ — At home	, ferm, s				_ NO	281. LO	CATION (Street a	nd Number	or Rural Ro	ute Number.	
TISH STIEN	ETED	_ 。 _	Could not be datermined	building,	etc. (Spec	cify)							or Town, State)				
29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge death occurred at the line date and due to the same of the line date and due to the same of the line date and due to the same of the line date and due to the same of the line date and due to the same of the line date and due to the same of the line date and due to the same of the line date and due to the same of the line date and due to the same of the line date and due to the same of the sam										ner as state	ıd.						
HOSPITAL FUNERAL Within 72 TANT: If	COMPLI			R: On the beele of e												end menner a	a stated.
2 MEDICAL EXAMINER: On the beele of exemination and/or investigation, in my opinion, death occurred at the time, date and place, 29b. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 20c. C. M. F.										29d. DATE	SIGNED (Month, Day, Yes	er)				
5 5 8 %	0	30. NAME AND ADDRESS OF	DEBGUN MIN	O COMPLETED CALL	SE OF DE	ATM STEEL O	70 /*	Deiret		0	C.M	LE.		D	EC_	17.19	94
		CIMIN M	R	611-10	SE OF DE				٠.								
		31. DATE FILED (Month, Day,		22. REGISTRA	R' SIGN	ATURE 1	Pe	nn	str	eet	. Bā	lti	more.	Mar	'y Lai	nd 21	201
		ner1 9100	14 901	MA WELLET	TAN	44											

BALTIMORE, MARYLAND 21215-0020

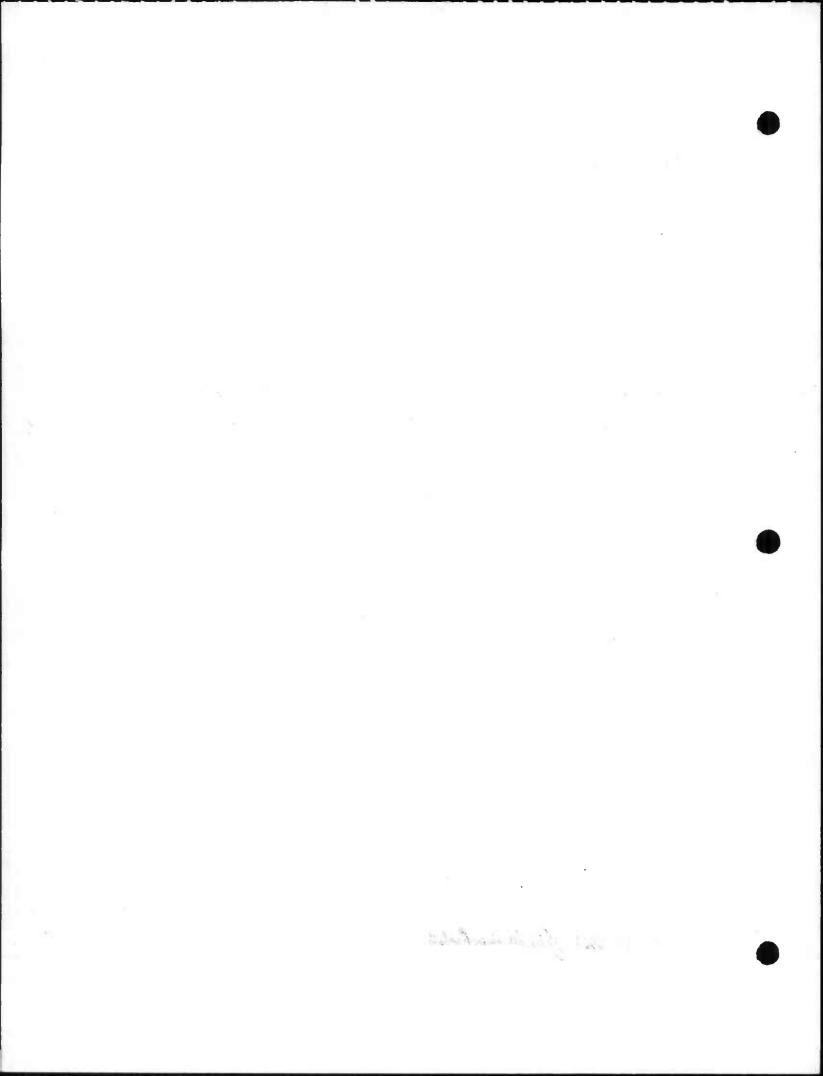
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
₹	CERTIFICATE OF DEATH	REG. NO.
		_

	1 - FOR STATE OF MA		ENT OF HEALTH AND MATE OF DEATH	ENTAL HYGIENE REG. NO.								
	1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH	3. TIME OF DEATH							
	JAMES ADAM KLOHR		b	December 16.	1994 9:20 PM M							
	4. SOCIAL SECURITY NUMBER 5. SEX 6.		INDER 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	BIRTHPLACE (State or Foreign							
	213-05-8409 A ¹⊠м²□F	79 YRS. MON	THS DAYS HOURS MIN.	Dec 7, 1915	Country) Maryland							
_	9a. FACILITY NAME (If not institution, give street and number)	9b.	CITY, TOWN OR LOCATION OF DEAT		COUNTY OF DEATH							
DIRECTOR	Meridian Nursing Home		Randallstown	allstown Baltimore County								
EC	10a. STATE 10b. COUNTY	10c. CITY, TO	WN OR LOCATION		10d. INSIDE CITY							
	Maryland Baltimore Co.	Rock	dale		LIMITS?							
AL	10e. STREET AND NUMBER	<u> </u>	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?								
FUNERAL	3617 Eitemiller Rd.		21244	21244 USA								
5	11. MARITAL STATUS 1 □ Never Married 2 ☑ Married 12. WAS DECEDENT E FORCES? 1 □		13. WAS DECENDENT OF HISPANIC If yes, specify Cuben, Maxican,	ORIGIN? (Specify Yea or No-	- 14. RACE — American Indian, Black, White, atc.							
B	3 Widowed 4 Divorced IF YES, GIVE WAR		1 TYES 2 NO Specify:		Specify: White							
	15. DECEDENT'S EDUCATION	16a. DECEDENT'S USU/	AL OCCUPATION	16b. KIND OF BUSINESS.								
<u> </u>	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	(Give kind of work of life. Do NOT use retir	lone during most of working	Total falls of boomings.	, mooth i							
립	12 years	Welder		Klohr Repa	air Service							
COMPLETED	17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME	E (First, Middle, Maiden Sumam									
ш	Adam Klohr	Kathr	yn Bowen									
TO B	19a. INFORMANT'S NAME (Type/Print)	RESS (Street and Number or Rural Roo										
	Mrs. Hilda Klohr		temiller Rd. B									
	20a. METHOD OF OISPOSITION 1 XX Burdel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetery or other place) 20c. LOCATION — City or Town, State											
	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	Lake View Me	morial Park 22. NAME AND ADDRESS OF FACIL	12-20 Sykes	ville, MD							
	Dohn K Annel		Loring Byers Fu	neral Direct								
		//	3728 Liberty Rd	. Randallst	own, MD 21133							
	23. PART i. Enter the diseases, or complications that cr shock, or heart feliure. List only one cause	usad tha death. Do not e on each lina.	nter the mode of dying, such	as cardisc or respiretory	arrest, Approximate interval Between							
	IMMEDIATE CAUSE (Final disease or condition Preum	Onset and Death										
	resulting in death)	AS A CONSEQUENCE OF):										
,	- multi-	manet De	mentra"									
<u> </u>	Sequentially list conditions, if any, leading to immediate	AS A CONSEQUENCE OF):										
S	cause. Enter UNDERLYING CAUSE (Disease or injury	DUE TO (OR AS A CONSEQUENCE OF): Bed and Chan Confirment DUE TO (OR AS A CONSEQUENCE OF): Cerebras when Discure										
E	that initiated evanta DUE TO (OR resulting in death) LAST	AS A CONSEQUENCE OF):	- 4 4									
CERTIFICATION	d. delete	saven the										
AL (PART II. Other aigniticant conditions contributing to de-	th but not resulting in the	a underlying cause givan in Pa	ert i. 24a. WAS AN AUTOP								
5	pypur arthuris	, CHF, A	-Fiballetin	PERFORMEO? 1 ☐ YES 2 ☐ NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
PHYSICIAN: MEDIC		/			1 TES 2 NO							
ÿ	DID TOBACCO USE CONTRIBUTE TO CAUS	E OF DEATH YES [NO UNCERTAIN									
2	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:	26. PLACE OF OEATH (C)	neck only one) HER:									
IYS	1 YES 2 NO 1 Inpetient 2 EF	/Outpetlant 3 DOA 4 D	Nursing Home 5 - Realdence 6									
	1 Netural 5 Pending (Month, Day, 1	JRY 28b. TIME OF INJURY	28c. INJURY AT WORK? M 1 YES 2 NO	26d. DESCRIBE HOW INJURY	OCCURED							
B	2 Accident Investigation 3 Suicide 6 Could not be 26s. PLACE OF IN	JURY — At home, term, street		28f. LOCATION (Street and Num	Ther or Rural Pouts Number							
COMPLETED	4 Homicide datarminad building, alc.	(Specify)		City or Town, State)	ion of right house humber,							
9	29a. CERTIFIER (Check only CERTIFYING PHYSICIAN: To the best of my	knowledge death occurred at	the time data and place and due to									
MP	(Check only one) 2 MEDICAL EXAMINER: On the basis of exam											
	29b. SIGNATURE AND TITLE OF CENTIFIER	0	29c. LICENSE NUMB									
H	New 17/1	du	D 23	679 D	DATE SIGNED (Month, Play, Year)							
2	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF	F DEATH (ITEM 27) (Type, Print)		, , ,	Owing mills							
	Kennetz L Glick	mp 20	Crossroids 1	Dr Suite 12	mozIII							
	DECT 9 1994 July 3 REGISTRAR'S	AGN/TUDE										
	DEOT O MOT											





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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.											
1. DECEDENT'S NAME (First,	e h	ehler				2. DATE OF DEATH MONTH DAY PLAN PLAN PLAN PLAN PLAN PLAN PLAN PLAN				TIME OF OEATH			
4. SOCIAL SECURITY NUMBER \$\int \ 5. SEX 6. AGE (In				In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HI				(Month, Day, Year) C			BIRTHPL Country) MARYI	ACE (State or Foreign	
90. FACILITY NAME (If not ins				96. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY									
	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY TOWN OR LOCATION 10												
364 73777 43773						TONSVILLE				10d. INSIDE CITY LIMITS? 1 YES 2 NO			
10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF									N OF WHA	T COUNTRY?			
742 EDMONDSON AVENUE											.S.A.		
11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DAT				2 NO If yes, specify Cuban, Maxican					n, Puarto Rican, atc.) Black			American Indian, fhita, atc. WHITE	
15. DECE (Specify only	DENT'S EDUCAT	TION mpleted)		CEDENT'S U				16	16b. KIND OF BUSINESS/INDUSTRY				
	Elementary/Secondary (0-12) College (1-4 or 5+)				(Give kind of work done during most of working life. Do NOT use retired.) PRINTER				BALTIMORE SALES CORP.				
17. FATHER'S NAME (First, Mic	idle, Last)						18. MOTHER'S NA	ME (First,	Middle, Malden S	iurname)			
WILLIA	M KOI	EHLER					CATH	ERIN	IE				
19a. INFORMANT'S NAME (Ty)			19b	MAILING A	DDRE	SS (Street ar	d Number or Rural	Route Nur	nber, City or Town,	State, Zip Co	ode)		
NATALIE A. K			74	42 ED	MON	DSON	AVENUE,	BAI	TIMORE	, MD.	2122	28	
20a, METHOD OF DISPOSITION 1 12 Buriel 2 Cremation 3 Ramoval from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of Campaign) 20c. LOCATION — City or Town, State 4 Donation 5 Other (Specify) BALTIMORE, MARYLAND													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY STERLING ASHTON FUNERAL HOME, INC.). 21228		
IMMEDIATE CAUSE (Find disease or condition reauting in death) Sequentially list condition from the cause. Enter UNDERLY!N CAUSE (Disease or injurthat initiated events	and and and and and and and and and and	DUE TO (OR AS	A CONSEO	CTION UENCE OF):	:	T GIA THOS	a or dying, suc		diac or respir	atory arrea	τ,	Approximate Interval Batween Onset and Death	
PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)						cause given in	PERFORM 1 YES 2		ED?	AMAILABLE PRIOR TO			
EXAMINER?	F	OSPITAL:			OTHE	R:				·			
27. MANNER OF DEATH	'	Inpetient 2 ER/Out 28a. DATE OF INJURY	Pertiant 3	28b. TIME	OF	28c. INJU	RY AT	☐ Residence 8 ☐ Other (Specify) IT 28d, DESCRIBE HOW INJURY OCCURED					
1 Natural 5 Pending (Month, Day, Year) INJURY					WOF	WORK?							
2 Accident Investigation 3 Suicide 8 Could not be defarmined 28a PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify)						281. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
		N: To the best of my know										ed manner as stated.	
296. SIGNATURE AND TITLE OF CERTIFIER MANAGER						29c. LICENSE NUI							
	NOTA DILLIK	ST. AGNES	7 H620	27) (NOO. P	Print)	ico CA	TON AVENU	t	BRITIMON	E, MAN	y UNI		
DEC 1 9 19	94 1	32 REGISTRAR'S SIGN	L										

The table of the second of the

permit. Pages 1, 2, 3 should use as the burial-transit Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020 10 funeral director, page 5 should be detached at once notified 8 must examiner signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. the medical event, DIVISION OF VITAL RECORDS, P.O. BOX 68760, traumatic OR ATTENDING PHYSICIAN: The law requires that the death certificate be 0 shows any has been Dept. of I 23 this certificate h Item 0 marked, After death 28 is after . DIRECTOR hours If Item THE HOSPITAL (THE FUNERAL D filed within 72 h TO THE HOSPITA
TO THE FUNERA
De filed within 7.

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ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-719 1/23/95 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) SOO-JUNG KONG 2. DATE OF DEATH 3. TIME OF DEATH DEC. KYUNG Κ. KONG 94 0126 Α 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign DAYS 1 M 2 TF 231-39-5539 36 DEC. 9,1958 KOREA 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR ANNE ARUNDEL GENERAL HOSPITAL ANNAPOLIS ANNE ARUNDEL 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY VIRGINIA VIENNA FAIRFAX 1 YES 2XXNO FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 201 ROSS DRIVE, SW 22180 KOREA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. RACE — American Indian, Black, Whife, etc. 1 Never Merried 2 Merried
3 Widowed 4 Divorced 1 TES 27 NO Specify Specify: ASIAN BΥ ETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grad Elementery/Secondery (0-12) College (1-4 or 5+) COMPL 12 STUDENT **EDUCATION** 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) CHONG SUN KONG YON HYO CHUNG 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 CHIN S. KONG 4605 JOHN TYLER COURT #202, ANNANDALE, VA 22003 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, Stata TIMORE-WASHINGTON CREM LAUREL, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICER 22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MD 20707 23. PART I. Enter the diseeses, or complications that death. Do not anter the mode of dying, euch es cerdiac or reepiratory strast, shock, or heart fellure. List only one ceuse Interval Batween IMMEDIATE CAUSE (Final Onset and Death disease or condition BLUNT FORCE INJURIES OF THE HEAD resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS **AMILABLE PRIOR TO** COMPLETION OF CAUSE 1 YES 2 NO 1 NES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \square NO \square UNCERTAIN \square PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) 1XXES 2 NO 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 266. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural :20 AM 1 YES 2 XXNO 12/11/94 UNKNOWN ВY 2 Accident Investigation 26s. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number City or Town, State) CROWNSVILLE STATE HOSPITAL, CROWNSVILLE, MD. 3 Sulcide COMPLETED 8 Could not be 4 Homicide HOSPITAL HOSPITAL. 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner ee stated. MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner ee stated. 29b. SIGNATURE AND TIFLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE

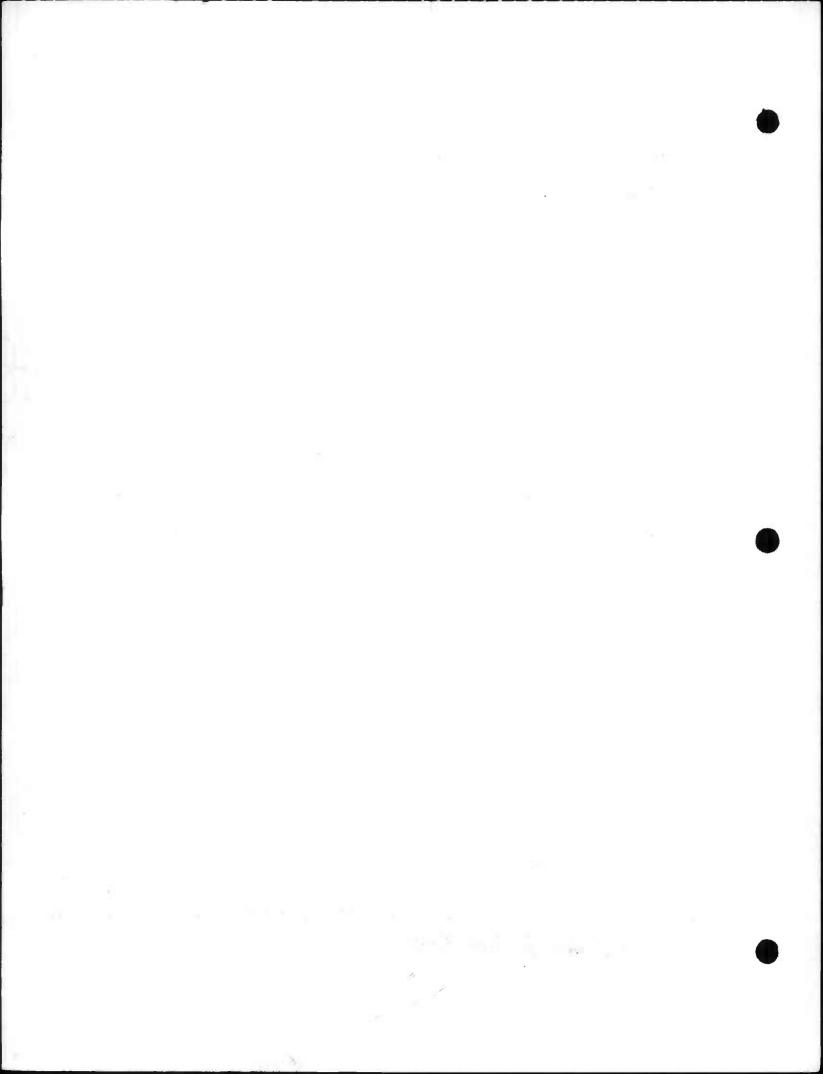
30. NAME AND ADDRESS OF PERSON WHO COMPRETED CAUSE OF DEATH (ITEM 27) (Type, Print)

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

▶ DEC. 12,1994

31, DATE FILED (Month, Day, Year)



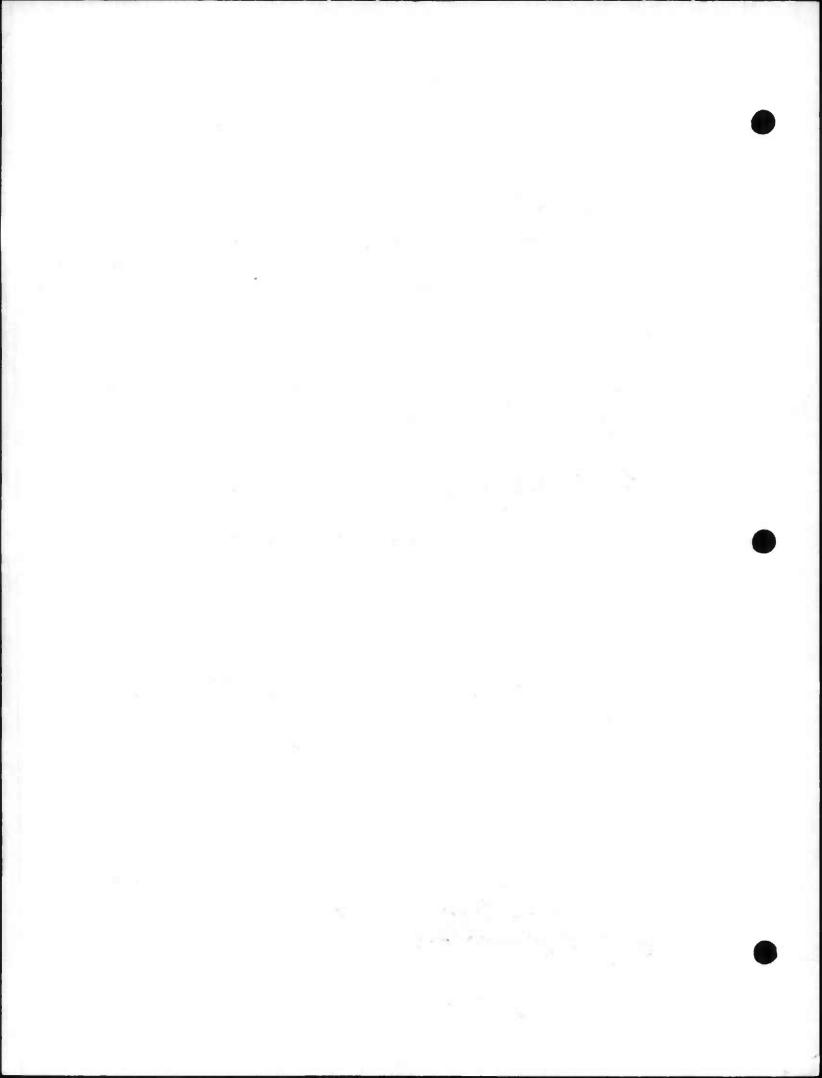
BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

R ATTENDING PHYSICIAN: The law requires that the death certificate be executed with hours after death. Page 6 may be retained by the hospital or attending physician.	RECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	urs after death with the State Oept. of Health and Mental Hygiene prior to burtal, cremation, or removal.	IMPORTANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSIC	TO THE FUNERAL DIRECTOR: After this ce	be filed within 72 hours after death with th	PORTANT: It item 28 is marked,
10	10 1	be file	IMPC

FOR 1 - STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	REGISTRAR			RHILL	CALE	UF	DEAL	п	REC	G. NO.			
- //	1. OECEDENT'S NAME (First, Middle, Lest) HABIB KARA								2. DATE OF DE		1994	YEAR	3. TIME OF OEATH 7:30 P.
	4. SOCIAL SECURITY NUMBER	5. SEX 6	S. AGE (In yrs. last	hirthday)	IF UNDER 1 YEAR		4 MDC	7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign			
1	220-19-5779	1 M 2 D F	86	YRS.		AYS		MIN.	(Month, Day,	Year)	8	Countr	DIA
	9a. FACILITY NAME (If not institution, give :		9b. CITY, TO	O NWC	R LOCATION	N OF DEA	TH		9c. COU	INTY OF O	EATH		
Œ	2842 MOZART DRIVE				9	SILV	ER SPR	RING			М	ONTGO	MERY
K	RESIDENCE OF DECEDENT												
ĬŽ	10a. STATE 10b. COUNT			10c. CITY	, TOWN OR	LOCATI	ION						10d. INSIDE CITY
DIRECTOR	MARYLAND I	MONTGOMERY			SI	LVE	R SPRI	ING					LIMITS? 1 YES 2 X NO
	10e. STREET AND NUMBER					101.	ZIP CODE				10a. CIT	IZEN OF V	WHAT COUNTRY?
FUNERAL	2842 MOZART DRIVE						209	2011				US	
Ž	11. MARITAL STATUS	12. WAS DECEDENT	EVED IN II C ADA	4ED	12 148	D OFCI			C ORIGIN? (Spec	ald. Maa	as Ma		
	1 Never Married 2 X Married	FORCES? 1	YES 2XXN	0	If y	es, spe	city Cuben,	Maxican,	Puerlo Rican, e		or No-	Black	E — American Indian, k, White, atc.
BY	3 Widowed 4 Divorced	IF YES, GIVE WAS	R OR DATES		1	YES	2 📉 NO	Specify:				Specia	my: AN/ASTAN
	15. DECEDENT'S EDU	ICATION	16a. DEC	EDENT'S	USUAL OCCI	IPATIO	N		16b. KIND	OF BILE	IMESS/IM		NIV ASTAIN
E	(Specify only highest grade		(GIV	e kind of w Do NOT use	ork done duri retired.)	ng mos	at of working		100.11.11.0	0. 500		5001111	
7	Elementary/Secondary (0-12)	College (1-4 or 5 +)		INESS					IMP	ORT/	EXPOR	T	
COMPLETED	17. FATNER'S NAME (First, Middle, Last)												
						ŀ			E (First, Middle,	Maiden 3	Sumama)		
BE	MOHAMED ALLY KARA								I KARA				
9	19s. INFORMANT'S NAME (Type/Print)								oute Number, City				
	SHIRIN KARA		1 2	842 M	OZARI L	DRIV	E, SIL	_VER :	SPRING,	MARY	LAND	20904	
	20s. METHOD OF DISPOSITION 1 XXBuriet 2 ☐ Cremation 3 ☐ Ram	noval from Stata	20b. PLACE A						DATE 2				
	4 Donation 5 Other (Specify)		MARYLAN	DONAT									
- 4	21. BIGNATURE OF FUNERAL SERVICE LI	CENSEE			22. NA	ME AN	D ADDRESS	OF FACI	ILITY FLEC	K FU	NERAL	HOME	, INC.
	D. A.	Col			760)1 S	SANDY S	SPRIN	G ROAD,	LAUR	EL, M	ARYLA	ND 20707
	23. PART i. Enter the diseases, or	complications that	caused the dea	ith. Do n	ot antar th	a mod	da of dvin	a. auch	as cardiac o	reaple	atory ar	rest	Approximate
	shock, or heart feliure.	List only one cause	e on each iine.							. с ар	atory an	,	interval Between
	IMMEDIATE CAUSE (Final disease or condition		210	00.	الع	PN	Plan	100	IA				Onset and Death
ł	resulting in death)	8	OR AS A CONSEO			, ,	-						
		002 10 (0	AS A CUNSEU	UENCE OF);								i
O	Sequentially list conditions,	b	OR AS A CONSEO	UENCE OF	١٠								
EA	if any, leeding to immediate cause. Enter UNDERLYING	562 10 (0	A CONCEO	OLIVOL OF	,.								i
윤	CAUSE (Disease or injury that initiated events	C. DUE TO (O	OR AS A CONSEO	UENCE OF	1:								-
Ē	resulting in death) LAST				,-								i l
CERTIFICATION		d											1
	PART ii. Other significant condition	ne contributing to d	eath but not re	sulting l	n the unde	rlying	cause giv	ven in P	Part i. 24a. y		AUTOPSY	24b	. WERE AUTOPSY FINDINGS
EDICAL		(hara	nic OD	بغاف	1 Chu	,)	Leu	ad	1800d	YES 2			AVAILABLE PRIOR TO COMPLETION OF CAUSE
		COR	DIMRY	Q	ven	C	SO	del		160 2	_ 140	- 1	OF DEATH?
Σ								-					1 TYES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL					26 PI	ACE OF DEA	ATN /Cher	rk only one)				
S	EXAMINER?	HOSPITAL:			OTHER:		-						
<u>×</u>	27. MANNER OF DEATH	1 Inpetient 2 E		26b. TIME	Y		JRY AT	_	Other (Spec			- Course	
	1 Natural 5 Pending	(Month, Day,		INJU	JRY	WOI	RK?		28d. DEŞCRIBE	HOW IN	IJURY OC	COMED	
BY	2 Accident Investigation	24- Pt 405 05	Int HIPPY As be-				ES 2	-					
E	3 Suicide 6 Could not be 4 Homicide determined	building, at	INJURY — At hon c. (Specify)	ne, term, s	treet, factory	, office	1		26f. LOCATION City or Town		nd Numbe	r or Rural F	loute Number,
					_								
P	29a. CERTIFIER (Check only 1 CERTIFYING PHYS	ICIAN: To the beat of m	y knowledge, des	th occurre	d at the time	, data	and place, a	end due t	o the cause(a) a	nd man	ner as ata	rted.	
COMPLET	one) 2 MEDICAL EXAMINE	ER: On the basis of axes	mination and/or in	westigstion	n, in my opin	ilon, de	eath occured	d at the ti	ime, data and pi	ace, and	due to ti	he cause(a) and manner as stated.
	29b. SIGNATURE AND TITLE OF CERTIFIE	В					29c. LICEN	ISE NUME	BER		29d DAT	TE SIGNED	(Mpnth, Day, Year)
BE		Lalia D.	en			X	1) 12	350	271	İ	D. 1	12 4	190
2	30. NAME AND ADDRESS OF PERSON WI	O COMPLETED CALISE	OF DEATH STEM	27) (Type	Print)	/	9	<u>)</u> /)4		- 1	~ 1	1 14
	x 24/5 Musc	prove Ro	aH Su	ite	#20	5	Sliv	ier	Sprin	7	ME	120	0904
	ULUI 9 1984	32. RIIGISTHAR	S SIGNATURE						1	J			



BALTIMORE, MARYLAND 21215-0020	ISCIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	a certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOPPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a	TO THE TIME FALL PRECIDE. WHE this confincate has been signed by the attending physician and completely filled in by the function and completely filled in by the function of the filed in the state of the filed will be filed without the completely filled in by the function of the filed will be filed without the filed filled	IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLA	ND / DEPARTMENT CERTIFICATE	OF HEALTH AND I	MENTAL HYGIEN	E	
1112.00	1. DECEDENT'S NAME (First, Middle, Last)	ewis			2. DATE OF DEATH DATE OF DATE OF DEATH DATE OF	95	3. TIME OF DEATH
7	4. SOCIAL SECURITY NUMBER 225-60-0505	1 D M 2 XF 7	3 YRS.	DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 06-13-	2/ V	BIRTHPLACE (State or Foreign Country)
LOH	9a. FACILITY NAME (If not institution, give s	ical Cente	r Bal	timore	АТН	sc.'COUNTY	of DEATH
DIRECTOR	10a. STATE 10b. COUNT MARYLAND	n/a	toc. CITY, TOWN OR BAL	LOCATION FIMORE			10d. INSIDE CITY VES 2 NO
FRAL	1300 E	. LANVALE S	TREET apt.	101. ZIP CODE 21202		109. CITIZEN UNIT	OF WHAT COUNTRY?
BY FUNER	11. MARITAL STATUS t Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT	2 X X II	AS DECENDENT OF HISPAN res, specify Cuben, Mexical YES 2 NO Specify	n, Puarto Rican, etc.)		RACE — American Indian, Black, Whita, atc. Specify: BLACK
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCC (Give kind of work done du life. Do NOT use retired.) DOMESTIC	TUPATION ring most of working	16b. KIND OF BUS	own ho	
BE COM	17. FATHER'S NAME (First, Middle, Last) GEORGE L	. ВООТН			ME (First, Middle, Meiden RIA CONV		
2		XON		Street and Number or Rural F			ORE,MD#05
	20a. METHOD OF DISPOSITION **Device 2 Cremation 3 Ram 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC	ME	TROPOL TTAN	BAPT.CH.	CEM. 12-23	CATION — City 6	
	bee V.	3 bollons	W		CH FH1]		NORTH AVE.
	23. PART. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition	Complications that caused that caused the List only one cause on each	the death. Do not enter the line.	ne mode of dying, such	n sa cardisc or reapi	ratory srrest,	Approximate interval Between Onset and Death
	resulting in death)	DUE TO (OR AS A C	N	lure			
HILICATION	Sequentially list conditions, if sny, issding to immediate cause. Enter UNDERLYING	DUE TO (OR AS A C	CONSEQUENCE OF):	monia Accid	ent		П
u II	CAUSE (Disesse or Injury that initiated events resulting in death) LAST	DUE TO (OR AS A C	CONSEQUENCE OF):	7100100			
וכאר כ	PART II. Other significant condition	ns contributing to death but	t not resulting in the und	erlying cause given in	PERFOR	MED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
WEDIC	DID TOBACCO USE CONT	RIBUTE TO CAUSE OF	DEATH YES □ N	O UNCERTAIN	1	_ NO	OF DEATH?
SICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		B. PLACE OF DEATH (Check on OTHER:		11111		
	27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation	28e. DATE OF INJURY (Month, Day, Year)		Bc. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW II	JURY OCCURE	:D
	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY - building, atc. (Specify	- At home, ferm, street, factor	y, office	28f. LOCATION (Street a City or Town, State)	nd Number or Ru	ural Route Number,
CIMIC		ICIAN: To the best of my knowled					use(a) and manner ae stated.
O DE C	WILL THE SHIPE	M Resid	ent	29c. LICENSE NUM P0817	4	29d, DATE SIG	IS 194
-	NAME AND ADDRESS OF PERSON WH		H (ITEM 27) (Type, Print)				
	31. DATE FILED (YOUNG DIS 994	A Standard Sound	vill-				

91.54 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

INTERPORTED PAYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THEOTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. Item#19a Per F.H. Film# G-718 12/19/94R. M.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

	1 - STATE REGISTRAR		CE			F DEATH		REG. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)	Virgi	nia Lee				2.	DATE OF DEATH DA	" 15,1	YEAR 994	3. TIME OF OEATH
	4. SOCIAL SECURITY NUMBER 212-32-6717	5. SEX	6. AGE (In yrs. last	birthday) YRS.	IF UNDER 1 YE MONTHS DA		HRS. 7.	DATE OF BIRTH (Month, Day, Year) 04/18/191		8. BIRTH Countr	PLACE (State or Foreign
LOR	9a. FACILITY NAME (If not institution, give s 8104 Eleanore Te				9b. CITY, TO	on Location Dunda	OF DEATH		9c. COU	nty of D	EATH
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN OR L	OCATION				1	10d. INSIDE CITY
	Maryland	Baltimo	re			D	unda]	lk			LIMITS? 1 YES 2 NO
FUNERAL	100. STREET AND NUMBER 8104 Eleanore Te	errace				101. ZIP CODE	21222	2			States
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDEN	T EVER IN U.S. ARN YES 2 1 NO	MED O	If yes	DECENDENT OF	HISPANIC C	ORIGIN? (Specify Yea			— American Indien, , White, atc. ly:
	15. DECEDENT'S EDU	JCATION	18a. DEC	EDENT'S	USUAL OCCU	PATION		16b. KIND OF BUS	INESS/IN	DUSTRY	White
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12) 4 Years	College (1-4 or 5	(Giv	no kind of Do NOT u	work done during se retired.) SEWIFE	g most of working		Own	Hom	ne	
CO	17. FATHER'S NAME (First, Middle, Last)							First, Middle, Malden	Sumame)		
BE	John H. Dalton		=		1000000			Moore			
5	190. INFORMANT'S NAME (Type/Print) L. Mr. Eford H. Low	ounderm idermild	ILK 199			ore Ter		Number, City or Town Dundalk			nd 21222
	Riga. METHOD OF DISPOSITION Burlel 2 Cremation 3 Ram Donation 5 Other (Specify)	noval from State			of DISPOSITION (Iber place)		19/94		- 11	City or To	
	21. SIGNATURE OF FINERAL SERVICE LI	CENSEE	0		22. NAM	E AND ADDRESS	OF FACILIT	TY			
- 1	Dregon	50,3	end	_	792	2 Wise	Ave.	ral Home Dundalk	_ MT	21	
	23. PART I. Enter the sesses, or shock, or year setture. IMMEDIATE CAUSE (Final disease or condition resulting in death)	a. Meta	se on each line. State (OR AS A CONSECU	er	don	mode of dying	•		ratory sr	rest,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequantially list conditions, if sny, leading to immediata cause. Enter UNDERLYING CAUSE (Disesse or Injury that initiated events resulting in death) LAST	c	(OR AS A CONSEO								
MEDICAL (PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 NO						24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
	DID TOBACCO USE CONT	RIBUTE TO CA					RTAIN	X			
PHYSICIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER:	. /					
HYS	27. MANNER OF DEATH	28a. DATE OF	ER/Outpatient 3 [28b. TIM	E OF 28c	Home 5 Resid		Other (Specify) d. DESCRIBE HOW IN	JURY OC	CURED	
ВУР	1 Natural 5 Pending 2 Accident Investigation	(Month D	av rear)	IN.	M 1	WORK?	NO				
	3 Suicide 8 Could not be determined	28s. PLACE O building,	É INJURY — At hom etc. (Specify)	ne, farm, :	streel, factory,	office	281	I. LOCATION (Street a City or Town, State)	nd Numbe	r or Rumal R	oute Number,
COMPLETED	29a. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICAL EXAMINE										and manner as stated,
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIE	70~ N	W)			29c. LICENS					(Month, Day, Year)
F	30. NAME AND ADDRESS OF PERSON WHITE THE PROPERTY OF THE PROPE	MOJI	BE OF DEATH (ITEM	27) (Type)	Print) 5 Hbp	Kips Ba	yvie	w Circle,	Ba	to N	1021224
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		completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
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BALTIMORE, MARYLAND 21215-0020	hours after death. Page 6 may be retained by the hospital or attending phys	9
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BALIIMO	TO THE HOSPITAL OF ATTENDING THYSICIAN. The law requires that the death certificate be executed with	TO THE PUMERAL CHECKEN AMOUNT IN SOMETHING BEING SIGNED by the attending physician and completely filled in by the funeral director	
D	ofter d	the i	be filled within 72 hours after Destreen the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.
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	FOR 1 - STATE REGISTRAR	STATE OF MARYLAND		T OF HEALTH AND E OF DEATH	MENTAL HYGIEN REG. NO	_			
	1. DECEDENT'S NAME (First, Middle, Last)	1	1114		2. DATE OF DEATH MONTH D	1	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER	5. SEX AGE (In yrs. In	ist birthday) IF UNDE	R 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH	8.1	BIRTHPLACE (State or Foreign		
	240-27-5/86 9e. FACILITY NAME (If not institution, give s	10 M 2 CM 85	YRS. MONTHS	DAYS HOURS MIN.	12-30-1	(JEORGIA		
TOR	CHURCH A	ONE HOSPIT.	AL L	BALTINORI	- LAPYLAN	a coomit	OF SEATH		
DIRECTOR	HANLAND 106. COUNTY	Υ	BALTII	OR LOCATION YORE, MARS	LAND		10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
FUNERAL	2334 LAURE	TTA AVENUE		101. ZIP CODE 2/22	23	10g. CITIZEN	of what country?		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. AI FORCES? 1 TYES 2 IF YES, GIVE WAR OR DATES		WAS DECENDENT OF HISPA If yea, specify Cuban, Maxic 1 YES 2 NO Spec	can, Puarto Rican, etc.)	or No- 14.	RACE — American Indian, Black, White, etc. Specify: BLACK		
PLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	completed) (0	ECEDENT'S USUAL OF Give kind of work done to NOT use retired.	during most of working	166. KIND OF BU	SINESS/INOUST	TRY		
BE COMPI	17. FATHER'S NAME (First, Middle, Last) Source T	THRON TON	140438		AME (First, Middle, Maiden HAE MA	-	THRONTON		
TO B	198. INFORMANT'S NAME (Type/Print) MARY L. John		96. MAILING ADDRES	SS (Street and Number or Rura AURETTA AU	FOUTE Number, City or Town	1-	E MARLHAND		
	20a. METHOD OF OISPOSITION 1 Burtel 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from Stata cemetery, cr	AND DATE OF OISPO remetory or other piece		DATE 20c. LO	CATION - City	or Town, State		
	21. SIGNATURE OF FUNDED SERVICE LIC			NAME AND ADDRESS OF E	BROWN NORTH	COMM	WUNTY FIH		
	23. PART I. Enter the diseases for shock, or heart failure.	complications that caused the d List only one cause on each lin	eath. Do not ente	or the mode of dying, su	ch as cardiac or reep	Iratory arrest,	Approximate interval Between Onset and Deat		
	disease or condition resulting in desth)	a. DUE TO (OR AS A CONSE	Ble EQUENCE OF:	eding			days		
NOI	Sequentially list conditions, if any, leading to immediate	quentially list conditions, a Congestive Condising grantly year							
RTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	C. Chronic		el failur	_		Jean.		
CE	PART II. Other significant condition	d	resulting in the u	inderlying cause given in	n Part I. 24s. WAS AN	ALITOPEV	24b, WERE AUTOPSY FINDINGS		
MEDICAL					PERFOI	PMED?	AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO		
SICIAN: I	25. WAS CASE REFERRED TO MEDICAL			26. PLACE OF DEATH (C	theck only one)				
0	EXAMINER?	HOSPITAL: 1 Inpetient 2 ER/Outpetient 2	3 DOA 4 N						
S		28a. DATE OF INJURY	_	ectly) BE HOW INJURY OCCURED					
PHY	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	(Month, Day, Year)	- INJURY M	26a. PLACE OF INJURY — At home, term, street, factory, office 28f. LOCATION (Stre					
ED BY PHY		(Month, Day, Year) 28a. PLACE OF INJURY — At h	M		281. LOCATION (Street City or Town, State)		Rural Route Number,		
D BY PHY	1 Natural 5 Pending Investigation 3 Suicide 8 Could not be datarmined 29a. CERTIFIER (Check only 1 CERTIFYING PHYSI	(Month, Day, Year) 28a. PLACE OF INJURY — At h	ome, term, street, fa	Ictory, office	City or Town, State;	nner as stated,			

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BALTIMORE, MARYLAND 21215-0020	nours after death. Page 6 may be retained by the hospital or attending physician.	INERAL DIRECTOR And the contribution has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2	ion, of temporal. The medical examiner much he matified at owner.
DIVISION OF VITAL RECORDS, P.O. BOX 68760.	USPITAL OR MITE WITH PROMIT THE law requires that the death certificate be executed with mounts after death. Page 6 may be retained by the hospital or attending physician.	INERAL DIRECTOR ARTHUR certificate has been signed by the attending physician and completely	rint /z rous driet bearl with the state begit, of nearly and wental nythere prior to bunds, cleritation, or removal. NT if flow 28 is marked on flow 23 shows any injury or other trainmafts event the medical evantions must be notified at once.

	- 1	FOR STATE REGISTRAR DECEDENT'S NAME (First, Middle, Li				RTMENT OF ICATE OF		REG. NO),	3. TIME OF DEATN
		Don's El	CANOR.	Love				MONTH I	AY S	27 2340 pm
	O. C. C. C. C. C. C. C. C. C. C. C. C. C.	4. SOCIAL SECURITY NUMBER 219-26-7499	5. SEX 1 M 2 F	6. AGE (In yrs. 56	last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HR	48.4 46 (2) 14 1	L937	BIRTNPLACE (State or Foreign Country) Maryland
	TOR	9. FACILITY NAME (If not institution, give street end number) Carroll County Gen. Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Westminster Carroll				
	DIRECTOR	10e, STATE 10b, COL	100.00			y, town or Loca Millers	ATION		·	10d. INSIDE CITY LIMITS? 1 YES 2 Y NO
	FUNERAL	100. STREET AND NUMBER 5041 Rol		10f. ZIP COOE 21107			10g. CITIZ	EN OF WHAT COUNTRY?		
	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			ARMED NO	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee if yee, specify Cuben, Mexicon, Puerto Rican, etc.) 1 YES 2 NO Specify:			e or No—	14. RACE — American Indian, Black, White, etc. Specify: White
	COMPLETED	15, OECEDENT'S (Specify only highest g			DECEDENT'S (Give kind of life. Do NOT u	USUAL OCCUPAT work done during m se retired.)	ION ost of working	16b. KIND OF BU	SINESS/INDU	STRY
ei	MPL	8	Conege (1-4 of 5		Cafete	ria Worl	ker	Balto.	Count	y Schools
d at once.	ш	17. FATNER'S NAME (First, Middle, Last) James Hin				NAME (First, Middle, Maiden Surneme) Laura Bouldin				
be notified at once.	TO B	190. INFORMANT'S NAME (Type/Print) Charles A. L	ove, Sr.					ral Route Number, City or Tow lers, Md.		Code)
Snu		20e. METNOD OF OISPOSITION 1 Buriel 2 Cremetion 3 F 4 Donation 5 Other (Specify)	Removal from State	20b. PLAC cemetery,	CEAND DATE	of Disposition (Another place) Cemete:	ry Dec.	20,1994 Woo	ocation — co	ty or Town, State
or removal. medical examiner		21. SIGNATURE OF FUNERAL SERVICE	blianet	4		Eck	nd address of hardt Fi	racility uneral Chape	e1	21117 ngs Mills, Md.
of Health and Mental Hygiene prior to burial, cremation, or removal shows any Injury, or other traumatic event, the medical		23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death Cause of the Constant of the Consta								
or to buni	TION	Sequantially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF):								
Hygiene pric or other tra	CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST								
and Mental	MEDICAL CE	DAME II OU 1 MI . WILL III . WILL							24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
Health Jws ar		DID TOBACCO USE COI	NTRIBUTE TO CA	USE OF DE	EATH Y	S NO [UNCERT	AIN 🗆		
lept. of Health and Menta 23 shows any injury,	7	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	D		TN (Check only one OTHER:		y 10_pto====		
Dept. 23 :	× 1	1 YES 2 NO 1 Inpetient 3 DOA 4 Nursing Nome 5 Residence 8 Other (Specify) 27. MANNER OF DEATN 28e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE NOW INJURY OCCURED								RED
the State Dept.	HYSICIAN:	1 Natural 5 Panding (Month, Day, Year) INJURY WORK? 2 Accident Investigation (Month, Day, Year)								
the State Dept.	ву рну	1 Natural 5 Pending 2 Accident Investigation	on 28e. PLACE O	OF INJURY — At	home, ferm			28f. LOCATION (Street	and Number o	r Rumi Bouts Number
after death with the State Dept. 28 is marked, or item 23 s	ETED BY PHY	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 8 Could not determined	be 28e. PLACE 0 building,	OF INJURY — At arc. (Specify)	home, ferm,	street, factory, offi		281. LOCATION (Street City or Town, State	end Number o	r Rural Route Number,
death with the State Dept.	ED BY PHY	1 Natural 5 Pending Investigation 3 Suicide 8 Could not datermined 29e. CERTIFIER (Check only)	be description 28e. PLACE O building.	my knowledge,	desth occurr	street, factory, offi	e end place, end c	City or Town, State	nner ee statec	

9 Walter Street

the hospital or attending physician. e detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL ECORDS, P.O. BOX 68760,

	TO THE HOSPITAL OR ATTENDING PHYSICAL PROPERTY IN THE HOSPITAL OR ATTENDING PHYSICAL Page 6 may be retained by the hosp	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache		IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	
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	- OR	DIR	be filed within 72 bours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	Iten	
	PITAL	RAL	22 6	5	
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR	STATE OF MARYLAND / DE	PARTMENT OF H		MENTAL HYGIE		
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATN		3. TIME OF DEATH
Erma M. Le	wis			MONTH 12	17 9	EAR 4 11:55 PM
00 04 701	6. AGE (In yrs. last birth	RS. IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTNPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street HOPKI'NS BOY	t and number)	9b. CITY, TOWN C	PR LOCATION OF DE		9c. COUNTY	OF OEATN
RESIDENCE OF DECEDENT	VICW	104	170.		100	(176
10a, STATE 10b, COUNTY	salto 100	Edgem	ere			10d. INSIDE CITY LIMITS? 1 X YES 2 NO
100. STREET AND NUMBER 2423 LIVICO	In Are) 101	ZIP CODE	7	10g. CITIZEN	OF WHAT COUNTRY?
11. MARITAL STATUS 1 Never Married 2 Married 3 Swidowed 4 Divorced	2. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 1 YES 2 ND IF YES, GIVE WAR DR OATES	It yes, sp		IIC ORIGIN? (Specify \n, Puerlo Rican, atc.)	es or No- 14.	RACE — American Indian, Black, Whita, atc.
15. DECEOENT'S EDUCAT (Specify only highest grade con		ENT'S USUAL OCCUPATION		16b. KIND OF B	USINESS/INDUST	TRY
		nd of work done during mo NOT use retired.)	tov	Balte	. Co	
17. FATNER'S NAME (First, Middle, Lest)			18. MOTHER'S NA	ME (First, Middle, Malde	n Surname)	
Hubert 19a. INFORMANT'S NAME (Type/Print)	Tankey 190. MA	ILING ADDRESS (Street a	nd Number or Rural F	adie I	anie	del
Mariorie L.	Evans 24	23 Lince	1 1 10	Edgem	1 A	d
29a METNOD OF DISPOSITION 1 Spurial 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	20b. PLACE AND Commenter C	PATE OF DISPOSITION (Na ry or other place)	me of	OATE 20c. I	OCATION — City	or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICEN	SEE	22. NAME AN	D ADDRESS OF FAC		pornare) 141
James a	7 7		Lauren.	s St. I	Sons latto.Mo	1.21217
23. PART i. Entar the disesses, or con shock, or haert fallure. Lie	npilcetions that caused the death. It only one cause on each line.	Do not enter the mo	da of dylng, suci	h ss cardiac or res	piratory arrest	, Approximate interval Between
iMMEDIATE CAUSE (Final disease or condition resulting in death)	UREMIA					Onset end Desth
resulting in death)	DUE TO (OR AS A CONSEDUEN	CE OF):				2 0233
Sequentially list conditions, b.	Renal Failure DUE TO (OR AS A CONSEQUEN					6 months
if any, leading to immediate cause. Enter UNDERLYING	Hypertension	,				20 1100 0
CAUSE (Disease or Injury that initiated events	DUE TO (DR AS A CONSEQUEN	CE OF):				go genis
resulting in deeth) LAST						
PART II. Other significent conditions of	contributing to death but not result	ting in the underlying	s acusa chuan la	Dord I or uno e	N AUTOPSY	
	The state of the s	ung in the underlying	I cease given in	PERF	ORMED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATN?
						1 TYES 2 NO
DID TOBACCO USE CONTRIE			UNCERTAIN	1 🗆 📗		
EXAMINER?	IOSPITAL:	OTHER:				
27. MANNER DF DEATN	Inpatient 2 ER/Outpatient 3 Do	OA 4 Nursing Nome D. TIME DF 28c. INJ	e 5 ☐ Residence	8 Other (Specify) 28d. DESCRIBE NOW	IN HIRY OCCUR	50
Netural 5 Pending Investigation	(Month, Day, Year)	INJURY WO	RK?	and. DESCRIBE NOW	INSONY OCCUR	EU
3 Suicide 8 Could not be determined	28a. PLACE DF INJURY — At home, to building, etc. (Specify)	erm, street, tectory, office		28f. LOCATION (Stree City or Town, Stat	t and Number or F	Rural Route Number,
	N: To the best of my knowledge, dash or					
2 MEOICAL EXAMINER: 1	On the beals of examination and/or invest	ligation, in my opinion, d	eath occured at the	time, data and place,	and due to the ce	ause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER	00-		29c. LICENSE NUM	BER	29d. DATE SI	GNED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO C	DMPLETED CAUSE OF OEATH (ITEM 27)	(Type, Print)	95015		12/	18 194
31. DATESPIERO (MONTO) A J.	tern Ave					
DECI 3 1994 Jul	The state of the s					

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HOSPITAL OR ATTINION PHYSICIAN: The law requires that the death certificate be executed within - hours after death. Page 6 may be retained by the hospital or attending physician.	FUNEAL DIRECTION And this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit. Pages 1, 2, 3 should	within 72 holys, after geth with the State Dept, of Health and Merital Hygiene prior to burial, cremation, or removal.	ITANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HC	THE FU	be filed with	MPORTA

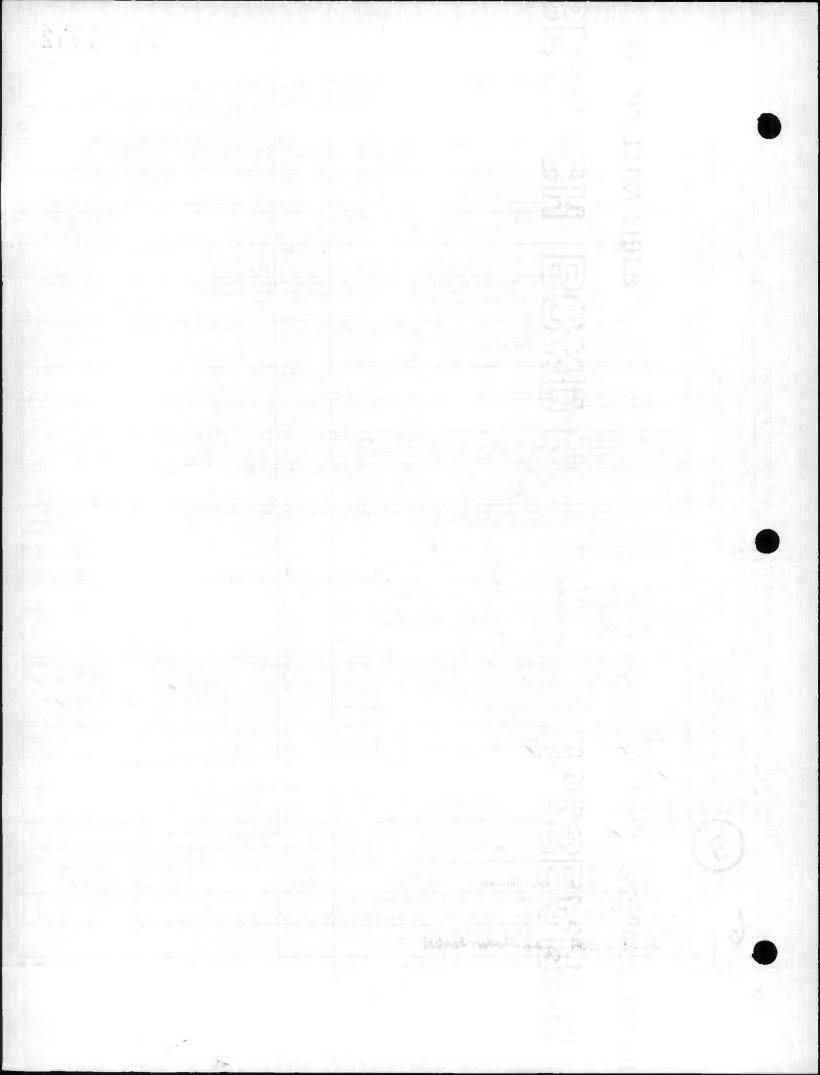
	1 - FOR STATE REGISTRAR	STATE OF MARYLAN	ID / DEPARTM			MENTA	L HYGIEN	E		
	1. DECEDENT'S NAME (First, Middle, Last) Ruth Esthe	er LeBrun					of DEATH	1994	YEAR 3.	TIME OF DEATH
	213 18 2090	□ M 2 X 2NE 82		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE	OF BIRTH	1912	County)	CE (State or Foreign
TOR	99. FACILITY NAME (If not institution, give street 3749 Glark's Po: RESIDENCE OF DECEDENT		9b.		dle Rive				y of DEAT Balti	
DIRECTOR	10a. STATE 10b. COUNTY	Baltimore	10c. CITY, TO	WN OR LOCAT	le Rive	r				d. INSIDE CITY LIMITS? YES 2 NO
FUNERAL	100. STREET AND NUMBER 3749 Glark's Po	int Rd.		101	. ZIP CODE 21220				N OF WHA	T COUNTRY?
BY FUNE		2. WAS DECEDENT EVER IN U. FORCES? 1 YES :	2 NO	II yes, sp	ENDENT OF HISPA ecity Cuben, Mexic 2 NO Speci	an, Puerto I				American Indian, hite, etc. White
COMPLETED		16N 18 **mpleted) College (1-4 or 5 +)	Give kind of work of the Do NOT use reti	done during mo ired.)	st of working	16b	. KIND OF BUS	SINESS/INDU	STRY	
OMP	17. FATHER'S NAME (First, Middle, Last)		Transfe	ormer	Ninder 18. MOTHER'S NA	AME (Elm)	_	ectron	nics	
BE CO	Robert Will	.ard				tie	Graype			
10	190. INFORMANT'S NAME (Type/Print) Loretta Ann Parks				nd Number or Rural Point R		ber, City or Town		,	220
	20e METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Removal	20b. PL	ACE AND DATE OF DE	SPOSITION (Ne		DAT		CATION - CI		
	4 Donetion 5 Other (Specify)	Sac	ry, crematory or other p	of Je	esus 12/	19/94	1 Ball	timore	, Ma	ryland
	(Som &	Lundy	udeo	1407	izinski Eastern	Ave	Bal	timore		21221
	23. Part I. Enter the diseases, or com ahock, or haart failura. List	iplications that caused the t only one cause on each	na death. Do not a n ilna.	nter tha mo	da of dying, suc	ch aa card	diac or respi	ratory arres	it,	Approximata interval Batween
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	DUE TO OR AS A CO	ONSEQUENCE OF):							Onset and Daeth
NOIT	Sequantially list conditions, if any, leading to immediate	DUE TO (OR AS A CO	ONSEQUENCE OF):						- 10	
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A CO	ONSEQUENCE OF):							
AL CE	PART II. Other algolificant conditions c	ontributing to death but	not resulting in th	a underlying	ı causa givan in	Part I.	24a. WAS AN			RE AUTOPSY FINDINGS
PHYSICIAN: MEDICA	CHT						PERFOR		DF	ILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO
AN:	DID TOBACCO USE CONTRIB 25. WAS CASE REFERRED TO MEDICAL		PLACE OF DEATH (C	NO [UNCERTAI	N□				
SICI	EXAMINER?	OSPITAL:	ОТ	HER:	5 Residence	6 Othe	r (Specify)			
F	27. MANNER OF DEATH 1 Natural 5 Pending	26e. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY	28c, INJI WO	JRY AT	_	CRIBE HOW IN	JURY OCCU	RED	
B	2 Accident Investigation	28e. PLACE OF INJURY —	At home, term, street	M 1 1 Y	_	261. LOC	ATION (Street e	nd Number or	Rural Route	Number
ETEC	4 Homicide 6 Could not be determined	building, etc. (Specify)		1000		City	or Town, State)		1,000	
COMPLETED		N: To the best of my knowledg								d menner es atated.
TO BE C	296 MANUS AND TITE ON CENTURY	U.D			20c. LICENSE NU	MBER S		29d. DATE :	GIGNED (Mo	gin, Day, Year)
	21 1- 10	Imon M.D.	7636		Rel.					
	DECT 9 1994 July	32. REGISTRAR'S SONATU	II,							

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	1. DECEDENT'S NAME (First,	Middle, Last)								2. DATE O				3. TIME OF DEATH
		MCCLE	NON							DECE	MBFR		994	3:10 A
	4. SOCIAL SECURITY NUMBER 218-01-155		5. SEX	6. AGE (In yrs. In 74	st birthday) YRS.	IF UNDE	DAYS	HOURS	24 HRS. MIN.	JAN	Day A Year)	920	8. BIRTH Country S .	PLACE (State or Foreign
	ea. FACILITY NAME (If not ins		street and number)			9b. CIT	Y, TOWN	OR LOCATIO	ON OF D	EATH		9c. COU	NTY OF D	
CTOR	THE JOHN	S HOP	KINS HOSI	PITAL		BA	TIN	40RF	CIT	Υ			n,	/a
ш	10a. STATE	10b. COUNT			10c. CI	TY, TOWN	OR LOC	ATION					T	10d. INSIDE CITY
DIR	MARYLAND		n/a			BA	LT	IMORE	E					1 AES 2 NO
PAL	10s. STREET AND NUMBER		122 CH	TNICHON	CMD	13 13 cm	1	of, ZIP CODE		2 2 2				HAT COUNTRY?
FUNERAL	1816	5 N.		INGTON			WAS DE	CENDENT O	212	NIC ORIGIN?	(Reacity Van		TED	STATES
B	1 Never Married 2 1 1 3 Widowed 4 Divor		FORCES?	YES 2 WAR DR DATES			If yes, a		n, Maxici	an, Puerto Ri			Specif	- American Indian, White, etc.
9	15. DECE (Specify only	DENT'S EDU		(0	live kind of	S USUAL C	during n	TION nost of working	g	16b. I	CIND OF BUS	INESS/INC	DUSTRY	
COMPLET	Elementary/Secondary (0- 5 TH	12)	College (1-4 or 5	+)		oretired.)					FΛ	CTOF	v	
OM	17. FATHER'S NAME (First, Mic	ddle, Last)			LAD	OKLI	`	18, MOTH	IER'S NA	AME (First, Mi			/ T	
ш	EDDIE	MACE	ζ							ANNIE		SLEY	Z	
10 8	19a. INFORMANT'S NAME (Ty			.19						Route Numbe				
-	ANNIE		CKSON			6 N.	_	- "	NG					IMORE, M
	29. METHOD OF DISPOSITION 1		noval from State	20b, PLACE cometery, cn					PAF	RK 12		ATION —		S, MD
	21. SIGNATURE OF FUNERAL		CENSEE	6	1			AND ADDRES			120	AILL	3010	U / 11D
	· nee	, 2	1. Dol	land			WM.	. c.	MAF	RCH F	H1	101	E.	NORTH
	23. PARTY. Enter the disease, or ha iMMEDIATE CAUSE (Find disease or condition resulting in death)	ert fallure.	e. Due to	TROK	E OUENCE	OF):							,	Approximate interval Betwoen B
z	Accessor to the first		. B	ASILA	RI	ART	ER	7	HR	ombo	2250			12501
CATION	Sequentially list condition if any, leading to immed cause. Enter UNDERLYIF	liete		YPERT			N							2/0/
CERTIFIC	CAUSE (Discess or Injurthat initiated events resulting in death) LAST	y 1		O (OR AS A CONSE										
- 1	PART II. Other aignificar	nt condition	na contributing to	o death but not	reaulting	in the u	nderlyi	ng cause (given in	Part I,	24s. WAS AN		24b.	WERE AUTOPSY FIND
MEDICAL	PNEU	MON	IA								PERFOR			AMAILABLE PRIOR TO COMPLETION OF CAU OF DEATH? 1 YES 2 NO
PHYSICIAN:	25. WAS CASE REFERRED TO	MEDICAL					26. 1	PLACE OF D	EATN (C)	neck only one;)		1	
SIC	EXAMINER? 1 YES 2 NO		HOSPITAL:	☐ ER/Outpatient	B DOA	OTHE 4 Nu		me 6 🗆 Re	sidence	6 Other	(Specify)			
BY PH		Pending nvestigation	28a. DATE O	F INJURY Day, Year)	28b. Ti	ME OF JURY M	W	YES 2] NO	28d. DE\$C	RIBE HOW II	NJURY OC	CURED	
TED		Could not be letermined	26a. PLACE (building	DF INJURY — At hi i, atc. (Specify)	ome, farm,	, street, fac	ctory, off	lca			FIDN (Street a Town, State)	nd Number	or Rural F	loute Number,
OMP	(State of the state)		ER: On the best of) and manner as stat
TO BPC	29b. SIGNATURE AND TITLE	and	renca	- Me	1			29c. LICE		MBER		29d. DAT	E SIGNED	(Month, Day, Year)
F	PETER BRI	AVERI		ONOTT.	M 27) (Typ	olfe	57,	reet	Joh.	n Hop	okari	Huspa	al L	Baltimore
	ULUI 9 19			AR'S SIGNATURE Or Reveals.										



30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. 526 201 E. UNIVERSITY PKWY.

BALTIMORE, MARYLAND 21215-0020

permit. Pages 1, 2, 3 should

DIRECTOR

FUNERAL

BY

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9

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

9

DIVISION OF VITAL RECORDS, P.O. BOX 68760

olcian. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans.	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal.	IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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TO THE HOSPITAL OR ALLENDING PHYSIC	HE FUNE	led within	ORTANI
0	10	e a	IMP

Item # 1,16b,20c Film # G 718 12-19-94 N.A. Per funeral home STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 3. TIME OF DEATH t. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY Catherine CATHARINE McCLEAN DEC. 16, 1994 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS HOURS 1 M 2 K F SEPT 24,1907 220-03-2810 YRS. MARYLAND 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH ST. AGNES HOSPITAL BALTIMORE CITY RESIDENCE OF DECEDENT 10a. STATE 10h, COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? MARYLAND CATONSVILLE BALTIMORE 1 YES 2 XNO 10e. STREET AND NUMBER tog. CITIZEN OF WHAT COUNTRY? 116 HILTON AVENUE 21228 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. It yes, specify Cuban, Maxican, Puarto Rican, stc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: WHITE 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER Own OEN-HOME 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) JOHN. L. HILDEBRANDT ELIZABETH SANDFOX Μ. 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM C. McCLEAN 116 HILTON AVENUE, CATONSVILLE, MD. 21228 20a. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 1 Burial 2 X Cremation 3 Removal from State
4 Donation 5 Other (Specify) GREEN MOUNT CREMATORY 12-17-94 BALTIMORE, AMRYLAND 21. SIGHATURE OF TYNIHAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY STERLING ASHTON FUNERAL HOME, INC. lach 736 EDMONDSON AVE., BALTIMORE, MD 21228 23. PART t. Enter the disceesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heert failure. List only one ceuse on each line. interval Between **IMMEDIATE CAUSE (Final** Onset and Death RESPIRATORY INFECTION, CONSESTINE HEART FAILURE disease or condition 3 PAYS resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): SYR: HYPERTENSINE CARDIAL DISEASE Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated eventa reaulting in deeth) LAST PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I.

CHRONIC ATRIAL FIRELULATION 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE 24s. WAS AN AUTOPSY 1 TYES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO Y UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL OTHER t YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 Realdence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation М 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER D146Z July and title of certifier A 29d. DATE SIGNED (Month. Day, Year)

12/16/94 III MD

DHMH-16 Rev 1/89

BALT., MA, ZIZIS

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within serhours after death. Page 6 may be retained by the hospital or attending physician.

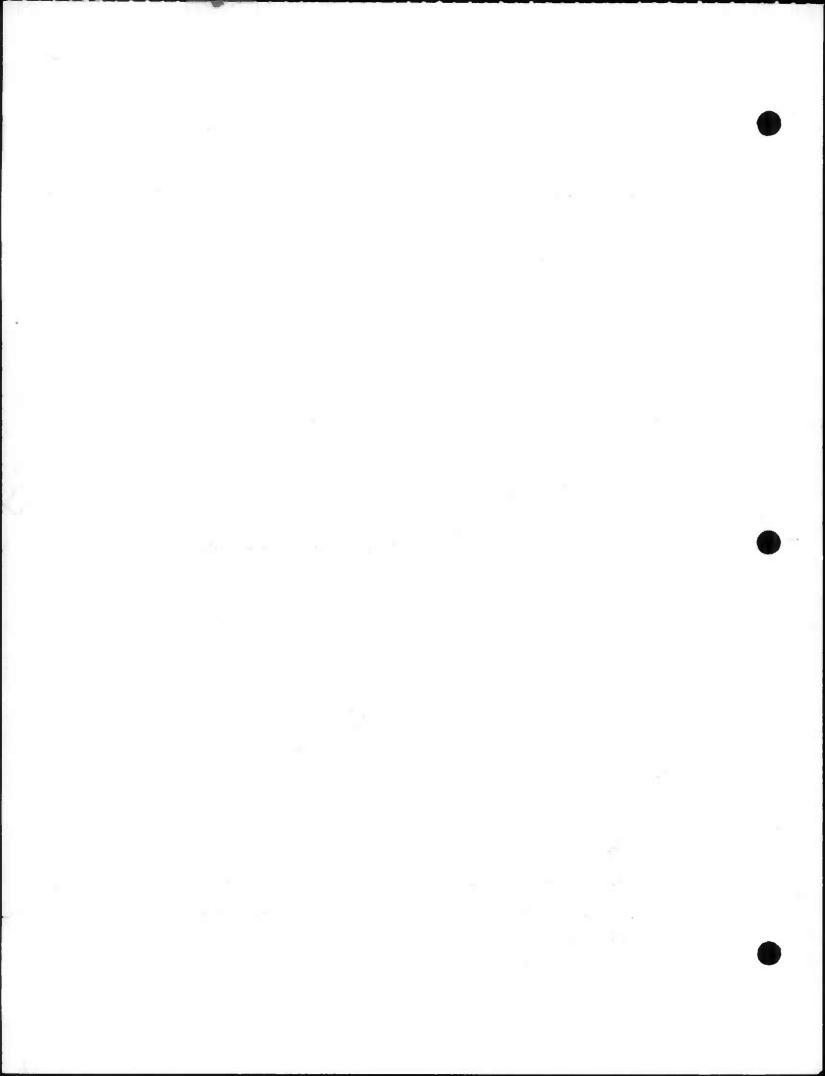
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF			GIENE		
8	1. DECEOENT'S NAME (First, Middle, Lest) HELEN M	MEISER				2. DATE OF DE MONTH	DAY	YEAR 94	3. TIME OF DEATN 5:35 P M
			n yrs. lest birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIF	TTN	8. BIRTH	IPLACE (State or Foreign
	218-54-0307	□ M 2 💥 F 8	2 YRS.	MONTHS DAYS	HOURS MIN.	OCT. 3	1,1912	MAI	RYLAND
_ [9a. FACILITY NAME (If not institution, give street	t and number)		9b. CITY, TOWN	OR LOCATION OF DI			UNTY OF D	
OH	BON SECOUR EXTENDE	D CARE		ELLIC	OTT CITY			HOWAE	CD CD
딥	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCA	TION				10d, INSIDE CITY
DIRECTOR	MARYLAND BA	LTIMORE		CATONSVI					LIMITS?
	10e. STREET AND NUMBER	ZI IIIOKE			LLLE f. ZIP CODE		10a, Cl	TIZEN OF Y	VNAT COUNTRY?
ER/	6 NUNNERY LANE	ī			2122	R			S.A.
FUNERAL		2. WAS DECEDENT EVER IN	U.S. ARMED		CENDENT OF HISPAI	VIC ORIGIN? (Spe		14. RACI	- American Indian,
BY F	1 Never Married 2 Married 3 Widowed 4 X Divorced	FORCES? 1 YES		If yes, s	ecity Cuban, Maxica 2 NO Specif	n, Puarto Rican, : y:	etc.)	Spec	k, White, atc.
									WHITE
	15. DECEDENT'S EDUCAT (Specify only highest grade con	ION ripleted)	16a. OECEDENT'S (Give kind of v life. Do NOT us	vork done durina m		16b. KINO	OF BUSINESS/IN	OUSTRY	
7	Elementary/Secondary (0-12)	College (1-4 or 5+)	HOMEM				OWN HO	MT	
COMPLETED	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME /First Middle		HE.	
		LSH			ANNA		,		
BE (19a. INFORMANT'S NAME (Type/Print)	2011	19b. MAILING	ADDRESS (Street	and Number or Rural			ip Code)	
٩	C. KEITH MEISER				RD., ATI				233
	20a, METHOD OF DISPOSITION 1 Surface 2 Cremetion 3 Remove	20b.	PLACEANDDATEC	F DISPOSITION /N	ame of	OATE	20c. LOCATION -		
	4 Donation 5 Other (Specify)	LÖ!	RRAINE P	ARK CEM	ETERY 12-	-19 V	VOODLAWI	N, MA	RYLAND
	21. SIGNATURE OF JUNERAL SERVICE LICEN	SEE			ND ADDRESS OF FA	CILITY			
	+ Hullys X	Mach		STER	LING ASHT	CON FUNI	ERAL HON	ME, I	NC. MD. 21228
	23. PART i. Enter the diseasea, or con	nplications that caused	tha daath. Do n	ot entar tha m	oda of dying, suc	h as cardiac o	r reapiratory a	rrest,	Approximsta
	ahock, or haart failure. Lie IMMEDIATE CAUSE (Final	t only one cause on as	ich iina.						Onsat and Death
		CARDIAC AF	REST						
	,		CONSEQUENCE OF	7):					
NO	Sequentisity list conditions,	METASTATIO			, UNKNOW	N PRIMA	.RY		
A	If any, laading to immediate cause. Enter UNDERLYING	OUE TO (OR AS A	CONSEQUENCE OF	7):					
임	CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A	CONSEQUENCE OF	7):					
CERTIFICATION	resulting in death) LAST								
	PART II Other elapiticent conditions of	contribution to death by							
PHYSICIAN: MEDICAL	PART II. Other significant conditions	ontributing to death bu	It not resulting I	n the undartyln	g cause givan in		MAS AN AUTOPSY PERFORMED?	24b	. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
						_ 10	YES 2 X NO		OF DEATH?
Σ	DID TOPACCO LICE CONTRIL	NITE TO CALICE O	F DEATH VE	6 T 110 F					1 TYES 2 NO
AN	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL		8. PLACE OF DEAT			<u>и </u>			
딩	EXAMINER?	IOSPITAL:		OTHER:					
Ä	27. MANNER OF DEATN	26a. DATE OF INJURY	26b. TIMI	E OF 28c. IN	ne 5 Rasidenca		NOW INJURY O	CCURED	
ВУ Р	1 K Natural 5 Pending	(Month, Day, Year)	INJ		PRK? YES 2 NO				
	3 Suicide 6 Could not be	25a. PLACE OF INJURY building, atc. (Speci	— At home, farm, s	treet, factory, offic		26f. LOCATION	(Street and Number	er or Rural F	loute Number,
ETED	4 Nomicide determined	bollong, atc. (opec	477			City or Town	n, State)		
7	29a. CERTIFIER 1 CERTIFYING PHYSICIA	N: To the best of my knowle	edge, death occurre	d at the time, date	and place, and due	to the cause(a) a	ind menner as at	nted.	
COMPL		On the beals of examination) and menner as stated.
BE C	296. SEPAREME AND THE OF CENTIFIER				29c. LICENSE NUI	ABER	29d. DA	TE SIGNED	(Month, Day, Year)
	KINDOW				3D117	2			ER 16, 1994
۵	30. HAME AND ADDRESS OF PERSON WHO O								
		LICOTT CENT		E, ELLIC	OTT CITY	, MARYL	AND 210)43	
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNA	TURE						
	DEC1 9 1994 July	Studen Rev	all						1

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		FOR 1 - STATE REGISTRAR	STATE OF MARYLA		TMENT OF		MENTA	L HYGIEN	E					
	1	1. DECEDENT'S NAME (First, Middle, Last)						OF DEATH			3. TIME OF OEATI	Н		
	1	Clarence Brya	nt Melto	n			Dec.	17,19		EAR	1217	M		
pin		213 32 3680	1 🕅 M 2 🗆 F	yrs. last birthday) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Mont) OCt.	OF BIRTH h, Day, Year) 12,19	936 Te	enne	essee	reign		
. 2, 3 should	TOR	99. FACILITY NAME (If not institution, give stre 837 Arncliff Road RESIDENCE OF DECEDENT	ncliff Road Essex							Poc. COUNTY OF GEATH Baltimore Co				
020 physician. burial-transit permit. Pages 1, 2,	DIRECTOR	10a. STATE 10b. COUNTY	ore County	10c. CIT	Y, TOWN OR LOCA						10d. INSIDE CITY LIMITS?			
n. ansit permi	FUNERAL	100. STREET AND NUMBER 837 Arncliff Road			10	0f. ZIP CODE 21221				S.A	HAT COUNTRY?			
BALTIMORE, MARYLAND 21215-0020 after death. Page 6 may be retained by the hospital or attending physician by the funeral director, page 5 should be detached for use as the burial-tran mosal.	BY FUN	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 TYPES IF YES, GIVE WAR OR DAY 1960-1963	2 NO	If yes, s	CENDENT OF HISPA pocify Cuben, Mexic S 2 NO Speci	en, Puerto I		or No — 14	Black,	American India White, etc.	n,		
MARYLAND 21215-0020 retained by the hospital or attending physic 5 should be detached for use as the burial notified at once.	COMPLETED	15. DECEOENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12)		18a. DECEDENT'S (Give kind of v life. Do NOT us Draftsn	vork done during m e retired.)	ION post of working	166	KIND OF BUS	siness/indus	TRY				
YLAND by the hospit be detached at once.		17. FATHER'S NAME (First, Middle, Last) Columbus Britt Me	Lton	2242 00.		18. MOTHER'S NA			Surneme)	_				
MARN e retained b : 5 should	TO BE	19a. INFORMANT'S NAME (Type/Print) Terry Norkitis				and Number or Rural Road Ess	Route Numi	ber, City or Town	n, State, Zip Co			\exists		
ALTIMORE, feath. Page 6 may be funeral director, page xaminer must be		20a. METHOD OF DISPOSITION 1 1 Burlat 2 Cremetion 3 Remov 4 Donation 5 Other (Specify)		PLACE AND DATE Of the Control of the	F DISPOSITION (A		DAT	E 20c. LO	CATION — City	or Tow	n, State aryland			
BALTIMORE, for death. Page 6 may by the funeral director, page nal.		21. SIGNATURE OF FUNERAL SETTOICE LICEN			22. NAME A	ND ADDRESS OF FA Zinski F Eastern	unera	al Home	e P.A.			221		
in 24 hours the filled in the medition.		23. PART . Enter the diseases, or conshock, or heart failure. List IMMEDIATE CAUSE (Finel disease or condition resulting in death)	DUE TO (OR AS A	ischer	mic a	condiova			A		Approxima interval Be Onset and	tween		
O.O. BOX 68 n certificate be execunding physician and Hygiene prior to bur or other traumatti	CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in deeth) LAST	DUE TO (OR AS A											
RECORDS, Frequires that the death been signed by the after she will be the signed by the after shows any Injury, it	MEDICAL C	PART II. Other significent conditions	contributing to deeth bu	it not resulting i	n the underlyir	ng cause given in	Part I.	24a, WAS AN PERFOR	MED?	6	WERE AUTOPSY FIN MAILABLE PRIOR T COMPLETION OF CO DE DEATH?	IO AUSE		
AL RE law requires law requires been 3 23 short	PHYSICIAN: M	DID TOBACCO USE CONTRI		DEATH YE			N 🗆				1 TES 2 N	°		
F VITAL SICIAN: The law certificate has the State Dept	SICI	EXAMINER?	IOSPITAL:		OTHER:	10		10				-		
SICIAL SICIAL Certifi h the	Ä	27. MANNER OF DEATH	28e. DATE OF INJURY	28b, TIM		JURY AT		CRIBE HOW IN	JURY OCCUR	ED		-		
ISION OF TJENDING PHYS TOR: After this of after death with 28 is marked.	Β¥	1 Matural 5 Pending Investigation 3 Suicide 8 Could not be	(Month, Day, Yeer) 28e. PLACE OF INJURY -	- At home, farm, a	M 1 🗌	ORK? YES 2 NO		ATION (Street e			ute Number	_		
DIVISION OF VITAL I OF ATENDING PHYSICIAN: The law DRECTOR: After this centificate has b rougs after death with the State Dept. Item 28 is marked, or Item 23:	LETED	4 Homicide determined	building, etc. (Specif	y)			City	or Town, State)						
Z 2 2 =	COMPLETE	(Check only one) 2 MEDICAL EXAMINER:	On the best of my knowle							Puse(s)	end manner as sta	ated.		
TO THE HOSPI TO THE FUNER De filed within	TO BE	J. C. Wollen O	nova,	m.b	٠	29c LICENSE NU	MBER 632		29d. DATE SI	GNED (Month, Day, Year) 9-94			
0		30. NAME AND ADDRESS OF PERSON WHO.	Joneran	M.)	2112	DUNDA	UK 1	AVE.	BAI	770	mD 2	.122		
		31. DATE FILED (NDEC 191994	32. REGISTHAR'S HIGHA	tions-Randa	ц									



BALTIMORE, MARYLAND 21215-0020

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DIVISION OF VITAL RECORDS, I	-
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TO THE MOSPITAL OR ALTENDING PHYSICIAN: The law requires that the death certificate be executed with. Abouts after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunk-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Ithm 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL		TMENT OF I		MENTAL HYGIEN			
100	1. DECEDENT'S NAME (First, Middle, Last) Harold McCuen					2. DATE OF DEATH	AY Y	SEAR 8:00 a	
	4. SOCIAL SECURITY NUMBER 215 32 7143	1 💢 M 2 🗆 F	fn yrs. last birthday) 58 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Morith, Day, Year) 0 9 / 1 1 / 1 9	36 W	BIRTHPLACE (State or Foreign Country) est Virginia	
DIRECTOR	9a. FACILITY NAME (If not institution, give s John Hopkins Ba RESIDENCE OF DECEDENT			Balti	more	EATH	9c. COUNTY OF DEATN		
EC	10a. STATE 10b. COUNT	Y	10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY	
	Maryland 10. STREET AND NUMBER		Ва	altimor				LIMITS?	
RA	7527 Berkshire	Dood		10	I. ZIP CODE			N OF WHAT COUNTRY?	
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER IN	U.S. ARMED	13. WAS DEC	21224	NIC ORIGIN? (Specity Ye		J.S.A.	
В	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 12 YES IF YES, GIVE WAR OR DA 1953	2 NO	If yes, sp	ecity Cuban, Maxica 2 X NO Specif	n, Puerto Rican, etc.)	10.	Black, White, etc. Specify: White	
COMPLETED	15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12)	CATION		USUAL OCCUPATI work done during me se retired.)		16b. KIND OF BU	SINESS/INDUS	TRY	
APL	10		Drywa.	ll Inst	aller	Constr	ructio	n	
SO	17. FATHER'S NAME (First, Middle, Last)				16. MOTNER'S NA	ME (First, Middle, Maiden	Sumame)		
BE (JAMES HAROLD MO	CCUEN			Freda	Ruker			
70	19a. INFORMANT'S NAME (Type/Print)					Route Number, City or Tox			
	Barbara Ann McC	uen	7527	Berksh	ire Roa	ad Baltin			
	20a. METHOD OF DISPOSITION 1 1 Burial 2 Cremetion 3 Ram 4 Donation 5 Other (Specify)	oval from Stata 20b.	PLACE AND DATE	TI Mem	. Gard.	12/16/94	cation — city Balto	or Town, Stata . Co . Md .	
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE	Mu	Bruzo	D ADDRESS OF FA	Funeral	Home	P.A.	
		man)						e Md 21221	
	23 ART I. Enter the diseeses, or cehock, or heert failure.	complications that caused List only one cause on e	I the deeth. Do r ech line.	ot enter the mo	de of dying, auc	h aa cerdiec or reep	iratory arrest	t, Approximate interval Between	
	IMMEDIATE CAUSE (Final disease or condition resulting in deeth)	Sarcoma						3 months	
		DUE TO (OR AS A	CONSEQUENCE O	F):					
O	Sequentially list conditions,	b DUE TO (OR AS A	CONSEQUENCE OF	n:					
SAT	if any, leeding to immediate cause. Enter UNDERLYING							į	
Ħ	CAUSE (Disease or injury that initiated events	DUE TO (OR AS A	CONSEQUENCE OF	F):					
CERTIFICATION	reaulting in death) LAST	d							
	PART II. Other eignificent condition	s contributing to death b	ut not resulting	n the underlyin	ceuse given in	Part I. 24a, WAS AN	AUTOPSV	24b. WERE AUTOPSY FINDINGS	
MEDICAL					g could give in	PERFO	MED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
						1 YES :	NO NO	OF DEATH?	
	DID TOBACCO USE CONTI	RIBUTE TO CAUSE O	F DEATH YE	S [] NO [UNCERTAI	N 1071		1 TYES 2 NO	
IAN	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEAT		JONGERIAN	14 (2)			
Sic	EXAMINER? 1 YES 2X NO	HOSPITAL: 1 Annetient 2 ER/Outp	atient 3 DOA	OTHER:	e 5 🗆 Realdence	6 Other (Specify)			
主	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	E OF 28c. IN.		28d. DESCRIBE HOW	NJURY OCCUR	IED	
١ ٠	1 Natural 5 Pending 2 Accident Investigation	(monn, bay, row)		M 1 🗆					
ENED BY PHYSICIAN:	3 Suicide 8 Could not be 4 Homicide datarmined	28e. PLACE DF INJURY building, etc. (Speci	— At home, farm, s	street, factory, offic	•	201, LOCATION (Street City or Town, State)	and Number or I	Rural Route Number,	
Z.	29a. CERTIFIER 1 X CERTIFYING PHYSI	CIAN: To the best of my knowl	edge, death occurre	ed at the time, date	and place, and due	to the cause(s) and ma	nner se stated.		
COMPL		R: On the basis of examination						ause(a) and manner as stated.	
	296. SIGNATURE AND TITLE OF CENTREES				29c. LICENSE NUI			IGNED (Month, Day, Year)	
) BE	No sold	2 (-	4	/	9502	7.7	1/2,	112/9V	
5	30. NAME AND ADDRESS OF PERSON WHO								
		Hopkins B		4940 E	astern	Ave Balt	o.,Md	. 21224	
	DECT 9 1994	ely develor has	lath						

BALTIMORE, MARYLAND 21215-0020

OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL, ON ATTENDANCE PHY CIAN: The law requires that the death certificate be executed with: Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL, UNITED BY A CHARLES AND STATE DEATH AND ACTUAL PAGES 1, 2, 3 should be filed within 72 hours are many men the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If I am 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

	MEGIOTIAN				OLITTI	ICATE	OI DI	LAIII	Н	EG. NO.			
1	1. DECEDENT'S NAME (First, A				CHA	LAK			2. DATE OF I	DA	ĭ3 ⁴	YEAR S	3. TIME OF DEATH 1905 M
	4. SOCIAL SECURITY NUMBE 216 01 6607		5. SEX	6. AGE (In yrs	(last birthday)		AYS HO		7. DATE OF E (Month, De 03 20	13		8. BIRTHP	
œ	99. FACILITY NAME (If not Institution, give street end number) Anne Arundel Hospital							DCATION OF DEA	ATN			NTY OF DE	
6	RESIDENCE OF DECEDENT						apol	LIS			MIII	e Aru	indel
DIRECTOR	Md.	10b. COUNTY				y, town or l ltimor		+					Od. INSIDE CITY LIMITS?
AL.	10e. STREET AND NUMBER						101, ZIP				10g. CITI		YES 2 NO
FUNERAL	338 Elrino	Stree	t				2	1224			USA		
BY	11. MARITAL STATUS 1 Never Married 2 Married 3 X Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2 WILDIVIDUAL FORCES? 1 FYES, GIVE WAR OR DATES					H y	s, specify	ENT OF HISPANI Cuben, Mexicen ₹NO Specify:	, Puerto Ricer	pecify Yes n, atc.)		14. RACE - Black, Specify White	
		DENT'S EDUC highest grade		160	. DECEDENT'S (Give kind of	work done duri	PATION ng most of	working	16b. KiN	O OF BUS	INESS/IND		
COMPLETED	Elementary/Secondary (0-1		College (1-4 or 5	+)	Seams	se retired.) tress			Ga	ırmer	nt		
BE CO	17. FATHER'S NAME (First, Mid- Joseph Na)				16.	MOTNER'S NAM	AE (First, Middl	e, Maiden	Sumame)		
10	Andrew J. M	ichala	ak		196. MAILING 1500	Oakda.	reet end No Le Ro	oad Arno	old, Mo	l. 21	012	Code)	
	20a. METNOD OF DISPOSITIO LX Buriel 2 Cremetion 4 Donetion 5 Other (S	3 Remo	val from State	cemetery	ceand dated crematory or o	ther place)		, 12–17–	DATE		EO., N	City or Town	n, State
	21. SIGNATURE OF FUNERAL	SERVICE LIC	Zerle			Ch.	arles	ooness of fac s S.Zei astern	ler &	Son	Inc.	1.	
	23. PART I. Enter the dia shock, or her	assea, or co	omplications the	t caused tha	daath. Do i	not antar th	mode o	of dyling, auch	aa cardlac	or reapi	ratory arr	aat,	Approximate interval Between
	iMMEDIATE CAUSE (Fina disease or condition	i			Ah	tourie	al	Aneu	14-1-6				Onset and Death
	resulting in death)	,	DUE TO	(OR AS A CON	ISEQUENCE O	F):		1 10160	rygen	1			3mas.
NO	Sequentially list condition		DUE TO	(OR AS A CON	SECHENCE O	D.							
CAT	If any, leading to immedicause. Enter UNDERLYIN CAUSE (Disease or Injury	G		(ou no n oo.	OLOGENOL O								
CERTIFICATION	that initiated eventa resulting in death) LAST		DUE TO	(OR AS A CON	ISEOUENCE O	F):						-	
	PART II. Other algolificant	t conditions	contributing to	death but n	ot regulting	In the unde	riving cau	use givan in P	Part i. 24e	. WAS AN	AUTOPSY	24h. V	YERE AUTOPSY FINDINGS
EDICAL			COPO				,	g		PERFOR	MED?	A	MAJLABLE PRIOR TO COMPLETION DF CAUSE
Σ			Bladd	lev co	ucev	^			_ ``				F DEATN?
SICIAN:	25. WAS CASE REFERRED TO	MEDICAL					8 PLACE	OF DEATH (Chec	ck only one)				
SIC	EXAMINER?		HOSPITAL:	ER/Outpetien	t 3 🗆 DOA	OTHER:		☐ Rasidence 6		ecify)			
ву РНУ	27. MANNER OF DEATN 1 Natural 5 Pr	ending vestigation	28e. DATE OF (Month, D		26b. TIM	URY	work?	AT 2 NO	28d. DESCRIE	BE NOW IF	JURY OCC	CURED	
- 11	3 Suicide 8 C	ould not be itermined	28s. PLACE O building,	FINJURY — A etc. (Specify)	t home, ferm,	street, fectory,	office		28f. LOCATIO City or To		nd Number	or Rural Roo	ste Number,
COMPLETED	anal .		IAN: To the best of										
w II	296, SIGNATURE AND TITLE O		0	0	/or investigation	m, in my opin	29c	LICENSE NUME	BER	pleca, en			Month, Day, Year)
10 8	39 NAME AND ADDRESS OF I	PERSON WHO	COMPLETED CAUS	SE OF DEATH	TEM 27) (Type	, Print)		01983			A	12/13	194
	Strait	E.	Selov	1104	Mo	90	0 6	sestoa	He Ra	. 1	444	apoli	is Ud. 21401
	31. DATE FILED (Month, Day, Ye DEC1 91994	Jalia	32. REGISTRA	R'S SIGNATUR	ie								

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Pages 1, 2, 3 should

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Exhours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit he field within 72 hours after death with the State Deat of Health and Mental Horison prior to hurial common	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 5:15 PM Newton Lillan Lillian Mary Newlon 12 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 216 12 7124 71 03 08 23 Maryland 1 M 2 DAYS HOURS YPS 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF DEATH Hopkins Bay View Medical Center DIRECTOR Baltimore Cityu RESIDENCE OF DECEDENT 10a STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Baltimore Eastwood 1 YES 2 1 NO FUNERAL 10e STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21224 7305 Conley Street USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—II yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 14. RACE - American Indian, Black, White, etc. 1 Never Married 2 Married В Specify: 3X Widowed 4 ☐ Divorced White COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) School Teacher 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname, Vito Ruggiero Margaret Tartagula BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John B. Newlon 1822 Walnut Avenue Balto., Md. 21222 20a. METHOD OF DISPOSITION
1X Burlal 2 Cremation 3 Ramoval from State 20b. PLACE AND DATE OF DISPOSITION (Name of OATE 20c. LOCATION — City or Town, Stata 12-17-94 4 Donation 5 Other (Specify) Overlea, Md. Gardens of Faith 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Charles S. Zeiler & Son Inc. 6224 Eastern Ave. Balto., Md. 23. PART I. Enter the dieeeses, or complice hone that caused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, Approximate shock, or heert feilure. List only one cause on each line. interval Betwe **IMMEDIATE CAUSE (Finel** Onset and Death disesse or condition_ end Stage lung cancer | severe COPD raculting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Diseese or injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in deeth) LAST PART II. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Pert i. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 1 TYES 2 OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\square\) NO \(\square\) UNCERTAIN \(\square\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF OEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 26a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident Investigation 26a. PLACE OF INJURY — At home, larm, street, factory, offica building, atc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide determined CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the lime, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITUE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 12/13/90 07692 2 PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 4940 Eastern Ave 9 1994

The Samuel Samuel Samuel Samuel



ed by the hospital or attending physician. uld be detached for use as the burial-transit permit. Pages 1, 2, 3 should BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760.

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	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shoul	be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.									
2000	1. DECEOENT'S NAME (First, Middle, Last) Casimir Richard Oles			2. DATE O			E OF OEATN	F OEATN DAY YEAR 11 - OO 2		
E COMPLETED BY FUNERAL DIRECTOR	4. SOCIAL SECURITY NUMBER 218 18 3172				F UNDER 24 HRS. HOURS MIN.	ns. 7. DATE OF BIRTN 8. E (Month, Day, Year)				
	96. FACILITY NAME (If not institution, give street and number) Hopkins Bay View Medical Center 96. CTY, TOWN OR LOCATION OF GEATH Baltimore City 96. COUNTY OF DEATH							ATN		
	10.00			TOWN OR LOCATION timore City						INSIDE CITY LIMITS?
	100. STREET AND NUMBER 5406 Daywalt Avenue				101. ZIP CODE 21 206			10g. CITIZEN OF WHAT COUNTRY? USA		
	11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS OECEDENT EVER IN U.S. A FORCES? 1.Z YES 2 IF YES, GIVE WAR OR DATES W.W. W. W. W. W.			ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Ye if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 X NO Specify:				es or No.— 14. RACE — American Indian, Black, White, atc. Specify: White		
	(Specify only highest grade completed) [Give kind of life. Do NOT of life. Do NOT of life. Do NOT of life. Do NOT of life.			ISUAL OCCUPATION ork done during most of working retired.) COCET			16b. KIND OF BUSINESS/INOUSTRY Grocery			
	17. FATHER'S NAME (First, Middle, Last) Joseph Oles			001	18. MOTHER'S NA	NAME (First, Middle, Meiden Surname) Colonia Chojnacki				
TO BE					S (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7alt Ave., Balto., Md.21206					
	4 🗋 Donation 5 🗆 Other (Specify)	20s. METHOD OF DISPOSITION 1 Surface 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of complex), repealory or other place) St. Stanislaus Cem. 12–14–94 Balto Md								n, Stata
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S. Zeiler & Son Inc. 6224 Eastern Ave. Balto. Md.									
	23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. ———————————————————————————————————							Interval Batween		
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated aventa reaulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): b. OUE TO (OR AS A CONSEQUENCE OF): oue TO (OR AS A CONSEQUENCE OF): d.									
AL	PART II. Other significant conditions contributing to death but not resulting in the underlying cause give Alzheimer's, Parkinsons					Part I.	PERFORMED? 1 YES 2 NO OF DEATH?		FERE AUTOPSY FINDINGS WAILABLE PRIOR TO OMPLETION OF CAUSE OF DEATH? YES 2 NO	
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)									
IYSIC	EXAMINER? 1 YES 2 NO NO NO NO NO NO NO									
ВУ РН	1 ONOTHER 5 Pending				JRY AT RK? 'ES 2 NO	28d. DEŞCRIBE HOW INJURY OCCURED NO				
	3 Suicide 8 Could not be 4 Homicide determined 28s. PLACE OF INJURY — At home, ferm, street building, atc. (Specify)				, factory, office 28f. LOCATION (Street and Number or Rural Roc City or Town, State)				ita Number,	
COMPLETED	29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To this best of my knowledge, dasth occurred at the time, date and place, and due to the cause(s) and menner as atted. 2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER A LACATION 30. NAME AND AGORESS OF PERSON WHO COMPLETED CAUSE OF GEATH (TEM 27) (Type				29c. LICENSE NUMBER 95021			29d. DATE SIGNED (Month, Day, Year) 1 / 5 / 94		
	31. DETETING 1984) Jahren Contraction E									



Page 6 may be retained by the hospital or attending physician. TIMORE, MARYLAND 21215-0020

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THE CONTROLLE OF THE CO	BALLIMORE, MARYLAND	dours after death. Page 6 may be retained by the hospita	d in by the funeral director, page 5 should be detached or removal.
THE OFFICE AND STATE OFFICE AND A STATE OFFI A STATE OFF			rety filled nation. o
B	MAISING OF VITAL RECORDS, P.O. BOA 50/00	OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed wil	JIRECTOR: After this certificate has been signed by the attending physician and comple ours after death with the State Dept. of Health and Mental Hygiene prior to burial, cre
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29b. SIGNATURE AND TITLE OF CHATAFIER

MARIA 31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE Mudleon Kardall

A. HALSTED MO

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH Lemuel L. Perry DECEMBER 14 02:24 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign JAN 22 DAYS HOURS 219-86-8417 X X M 2 □ F N.C 30 YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Union Memorial Hospital Baltimore City RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD Balto 1 X YES 2 - NO FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3527 Meadowside Road 21207 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2/ NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. it yes, specify Cuban, Mexican, Puerto Ric 1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES ВУ 3 Widowed 4 Divorced Specify B1ack COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) 11th Unknown 17. FATHER'S NAME (First, Middle, Leat) 16. MOTHER'S NAME (First, Middle, Maiden Surname) George Perry Margaret Hollev notifled 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margarett Perry 3527 Meadowside Road Balto, Md 21207 pe 20s. METHOD OF DISPOSITION
1 △ Burial 2 □ Cremation 3 □ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION — City or Town, Stata DATE must Wood Tawn Cemetery 121994 Balto, Md 4 ☐ Donation 5 ☐ Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEI 22. NAME AND ADDRESS OF FACILITY & rome March F/J Home West Je 4300 Wabash Avenue Balto Md 21215 medical 23. PART I Figure the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or haart failure. List pniy one cause on each line. interval Batweer IMMEDIATE GAUSE (Final disease or condition Onset and Death the ACUTE CENTRAL CIRCULATORY AND RESPIRATORY FAILURE 18HRS event, 1 resulting in death) DUE TO (OR AS A CONSEQUENCE OF): ACUTE HYPOVOLEMIA 18 NRS traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate BLEEDING AT TRACHEOSTOMY SITE 13 HRS cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST EROSION OF INNOMINATE ARTERY 13 HRS. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL shows any ANOXIC ENCEPHALOPATHY COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 - YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 🕱 UNCERTAIN 🗆 PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL OTHER: 1 YES 2 NO Inpetient 2 - ER/Outpetient 3 - DOA 4 ☐ Nursing Homa 5 ☐ Residence 6 ☐ Other (Specify) -0 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, Netural 5 Pending Investigation 1 YES 2 NO 2 Accident 26s. PLACE OF INJURY — At home, term, etreet, tactory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 60 8 Could not be 28 4 Homicide determined Tem I 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurs at the time, data and place, and due to the cause(a) and manner as stated.

29c. LICENSE NUMBER

AT2438946

UNION MEMOMAL HOSP 201 EAST UNIV PARKWAY BALT, MD 212/8

DHMH-18 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)

DECEMBER 14, 1994

and the

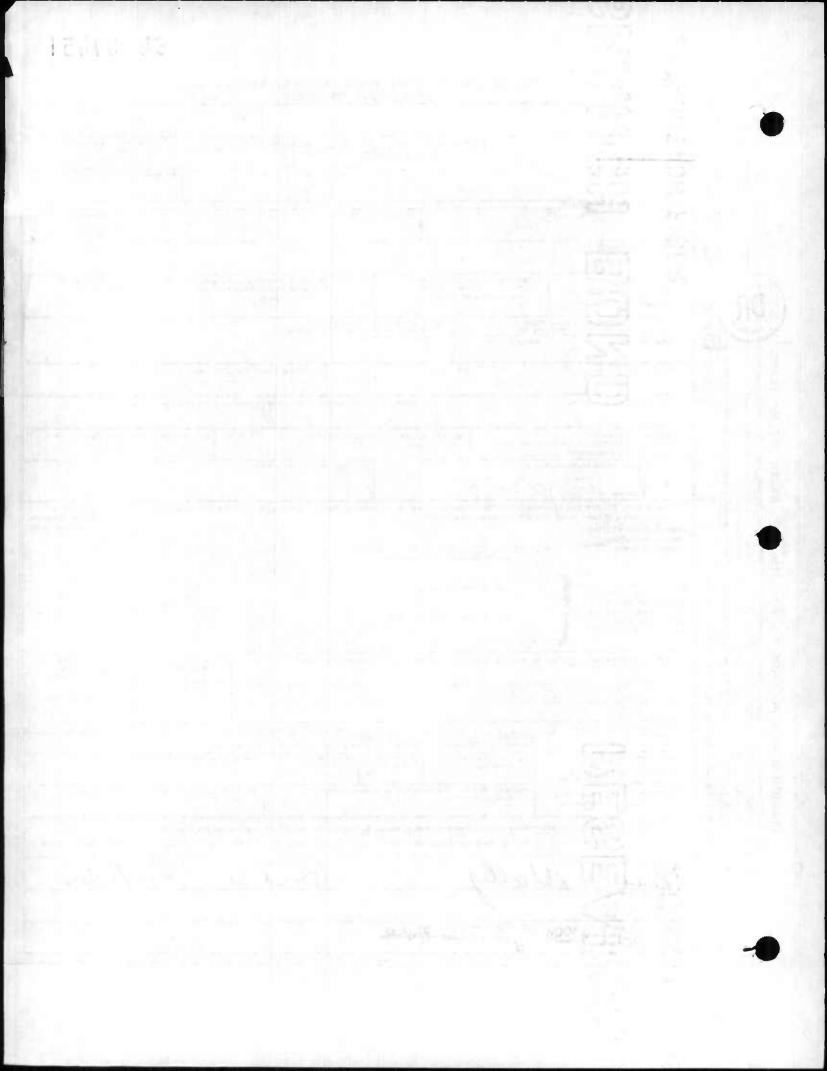
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BALTIMORE, MARYLAND 21615-0020	eath. Page 6 may be retained by the hosp	funeral director, page 5 should be detached	xaminer must be notified at once-
	Scate be executed within nours after d	physician and completely filled in by the re prior to burial, cremation, or removal.	er traumatic event, the medical ex
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	: The law requires that the death certifi	ate has been signed by the attending parte Dept. of Health and Mental Hygien	tem 23 shows any Injury, or oth
DIVISION OF VI	TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a nours after death. Page 6 may be retained by the hospital and a second or the hospita	TO THE FUNERAL DIRECTOR'S After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached in the second in	IMPORTANT: If Item 28 is marray, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once-

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

Pages 1, 2, 3 should

	REGISTRAR		CERTIF	ICATE OF	DEATH	REG	. NO.			
	1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF D			DEATH DAY YEAR 3. TIME OF DEATH				
TO BE COMPLETED BY FUNERAL DIRECTOR	Ethel Marie		PAINTER			Decembe		1994	6:22 am	
	4. 90C/A3 SECURITY NUMBER 2123 26 4755	5. SEX 6. /	AGE (In yrs. lest birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRT (Month, Dgy, Ye Apr. 15	ы	Balto	PLACE (State or Foreign	
	9a. FACILITY NAME (if not institution, give street and number) Franklin Square Hospital Center Residence of decedent 9b. CITY, TOWN OR LOCATION OF DEATH ROSSVIlle Baltimore							ATH		
				CITY, TOWN OR LOCATION ESSEX			10d. INSIDE LIMITS?			
	10o. STREET AND NUMBER 625 S. Marlyn Ave			10f. ZIP CODE 21221			10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES			ED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Spec				14. RACE Black, Specify	- American Indian, White, atc.	
	15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12)				ng most of working					
	? Housewife				18 MOTHER'S NA	Home				
	John Shalkelford				18. MOTHER'S NAME (First, Middle, Meiden Surname) Barbara Dotterwiech RESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
	190. INFORMANT'S NAME (Type/Print) Kenneth Wacker				Ave Bal				21	
	1 ☐ Burial 2 Ly Cremation 3 ☐ Removal from State cemetery crematory of			ther place!	DISPOSITION/Neme of DATE 20c. LOCATION — City or To Crematory 12/20/94 Baltimore Ma					
1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF EACHING Bruzdzinski Funeral Home P.A. 1407 Eastern Ave Baltimore Md 21221					
	00 2047 (2 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4								Approximate	
ATION	ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Acute Pulmonary Edema Due To (or as a conscourage on):									
	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING									
CERTIFICATION	CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):									
MEDICAL C	PERFORMED? 1 YES 2 NO						WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO			
AN	DE WAS CASE DESERBED TO MEDICAL									
COMPLETED BY PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 N NO 1 Nonetlent 2 FR/Outpetlent 3 DOA A Number to Represent the Property of the Computer									
	27. MANNER OF DEATH 1 Netural 5 Pending	(Month, Day, Year) INJURY WORK?					(Specify) RIBE HOW INJURY OCCURED			
TED	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, building, stc. (Specify)				vi, factory, office 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
OMPLE	29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.									
8	Signiffure and title of certifier 20d. DATE SIGNED. Quel D2C835 20d. DATE SIGNED.					Month, pay, Year)				
5	Paul Valle, M.D. 9000 Franklin Square Drive Balt, MD 21237									
	Paul Valle, M.D. 9000 Franklin Square Drive Balt, MD 21237 DEC 1 9 1994 32. REGISTRANCE SIGNATURE PROME									



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S, P.O. BOX	e death certificate be en	ne attending physician a	Mental Hygiene prior to	lury, or other traum
AL RECORD	e law requires that th	has been signed by t	Dept. of Health and	1 23 shows any in
DIVISION OF VITAL RECORDS, P.O. BOX	TO THE HOSPITAL OF ATTENDED PHYSICIAN: The law requires that the death certificate be ex	TO THE RINGRAL DESCRIPE CONTINUES OF THE BEST SIGNED by the attending physician a	after death with he State	IMPORTANT, If them 34 is marked, or item 23 shows any Injury, or other traum
DIA	TO THE HOSPITUL OF	TO THE FUNERAL DIFFE	the filed within 72 hours	IMPORTANT: If Ihem

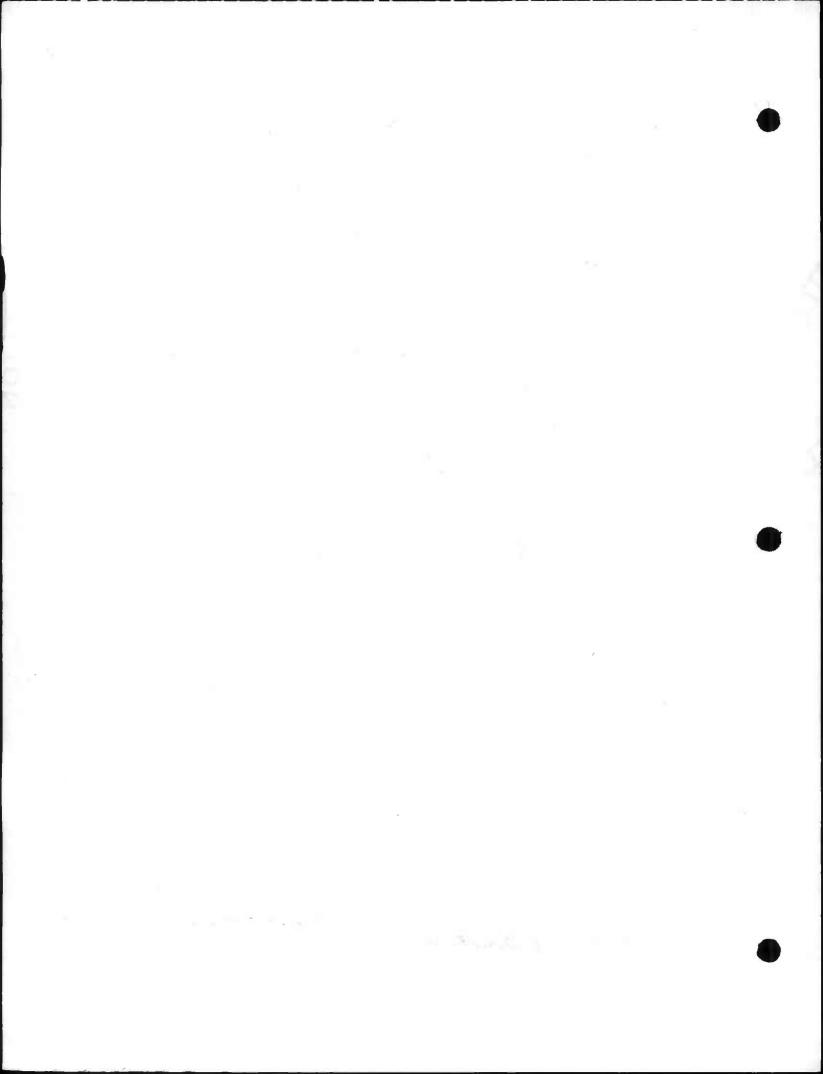
BALTIMORE, MARYLAND 21215-0020	The law requires that the death certificate be executed with fours after death. Page 6 may be retained by the hospital or attending physician.	at the cate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit permit. Pages 1, 2, 3 should be state. Dept. of Health and Mental Hygiene prior to buriat, cremation, or removal.	redical examiner must be notified at once.	
DE VITAL RECORDS, P.O. BOX 68760.	Sidals: The law requires that the death certificate be executed with	e crifficate has been signed by the attending physician and completely filled in by the in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	of ar item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.	

	FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIFI	TMENT OF HEALTH AN	ID MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Lest)	V10-00		0 = 4	2. DATE OF DEATH	AY YEAR	3. TIME OF DEATH
	VERDA 4. SOCIAL SECURITY NUMBER	VICTOR		REID		9 94	6427 m
		1 M 2 DxF 7	n yrs lest birthdey) YRS.	#FUNDER 1 YEAR #FUNDER 24 H	(Month, Day, Year)	Country	
	215 18 8975 9a. FACILITY NAME (If not institution, give street	7.	,	9b. CITY, TOWN OR LOCATION (May 1, 19	9c. COUNTY OF DE	est Va.
8	Carroll County Ge	eneral Hospi	tal	Westminste		Carro	
DIRECTOR	RESIDENCE OF DECEDENT] Oall	
1 1 1			10c. CIT	, TOWN OR LOCATION			10d. INSIDE CITY LIMITS?
	10e. STREET AND NUMBER	arroll		Westminster 101. ZIP CODE		10g. CITIZEN OF W	1 YES 2 NO
ER/	4207 Tekland	1 Drive		21157		U.S.A.	
FUNERAL	11. MARITAL STATUS 1	2. WAS DECEDENT EVER IN FORCES? 1 TYES		13. WAS DECENDENT OF H	SPANIC ORIGIN? (Specify Ye	e or No 14. RACE	- American Indian,
BY F	1 Never Merried 2 X Merried 3 Widowed 4 Divorced	IF YES, GIVE WAR OR O		1 YES 2 X NO S	exican, Puerto Rican, etc.)	Specify	
	15. DECEDENT'S EDUCAT	TION	16a, DECEDENT'S	USUAL OCCUPATION	16h KIND OF BU	Whit	.e
COMPLETED	(Specify only highest grade co	mpleted) College (1-4 or 5+)	(Give kind of w life. Do NOT us	ork done during most of working	TOO, KIND OF GO	3114E33/114D031 RT	
로	11		Assembly	Line Worker	Canni	ng Factor	·v
8	17. FATHER'S NAME (First, Middle, Lest)		1865/1969/1977		S NAME (First, Middle, Maiden		
BE	Francis William	Cline		Bert	ha Stell Mil	ler	
2	190. INFORMANT'S NAME (Type/Print)			AODRESS (Street and Number or F			
	Sherry Daniel 200. METHOD OF DISPOSITION	20h		7 Tekland Dr.		CATION — City or Tow	
	1 N Buriel 2 Cremetion 3 Remove 4 Donation 5 Other (Specify)	of from State cem	etery, cremetory or ot.	her place)	22 1994 De		
	21. SIGNATURE OF FUNERAL SERVICE LICEN	ISEE	Julu Jell	22. NAME AND ADORESS O		Azer M.	Va.
	+ Harry YII.	Thristot		P.O.Box 195	Sylvasyilla	Md 2170	<i>i</i> .
	23. PART i. Enter the diseases, or cor	iplications that caused	the death. Do n	ot enter the mode of dying,	such as cardiac or reap	iratory arreat,	Approximate
	ahock, of haart fallure. Lis	1-1-2		A			Interval Between Onset and Death
	disease or condition			lal myocaes	IAC IN HAN	rcam	
		OUE TO (OR AS A	CONSEQUENCE OF):			
ON	Sequentially list conditions, If any, leading to immediate	OUE TO (OR AS A	CONSEQUENCE OF);			
CAT	cause. Enter UNDERLYING CAUSE (Disease or injury						
F	that initiated events resulting in death) LAST	DUE TO (OR AS A	CONSEQUENCE OF):			
CERTIFICATION	d.						
AL (PART II. Other algnificant conditions	contributing to death b	it not resulting li	the underlying cause give	n In Part i. 24a. WAS AN		WERE AUTOPSY FINDINGS
EDIC	CHRONIC OBSTRO				1 TES 2	X	COMPLETION OF CAUSE OF DEATH?
≥	LEFT LUNG MA					•	I TES 2 XNO
AN	DID TOBACCO USE CONTRIL 25. WAS CASE REFERRED TO MEDICAL				IAIN 🗆 📗		
PHYSICIAN:		(9SPITAL:	26. PLACE OF DEAT	OTHER:			
H	27. MANNER OF OEATH	Inpetient 2 ER/Outp	28b. TIME		nce 8 U Other (Specify) 28d. DESCRIBE HOW I	NJURY OCCURED	
w .		(Month, Day bay)	INJU				
	1 Natural 5 Pending	l bitt	i	M 1 YES 2 NO			
) M	2 Accident Investigation 3 Suicide 6 Could not be	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm, si		281. LOCATION (Street	and Number or Rural Ro	ute Number,
	2 Accident Investigation	28e. PLACE OF INJURY building, atc. (Spec	— At home, farm, si			and Number or Rural Ro	ute Number,
	2 Accident 3 Suicide 6 Could not be determined 29s. CERTIFIER (Check only) 20s. CERTIFYING PHYSICIA	building, atc. (Spec	edge, death occurre	reet, factory, office	28t. LOCATION (Street City or Town, State) due to the cause(s) and mai	nner as stated,	
	2 Accident 3 Suicide 6 Could not be determined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER:	building, atc. (Spec	edge, death occurre	treet, factory, office	28t. LOCATION (Street City or Town, State) due to the cause(s) and mai	nner as stated,	
	2 Accident 3 Suicide 6 Could not be determined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATURE AND TITLE OF CERTIFIER	building, stc. (Spec	edge, death occurre	d at the time, date and place, and to, in my opinion, death occured a	281. LOCATION (Street City or Town, State) due to the cause(s) end me t the time, date and place, an NUMBER	nner as stated,	and manner es stated.
E COMPLETED	2 Accident 3 Suicide 4 Homicide 6 Could not be determined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATUTE AND TITLE OF CERTIFIER	IN: To the best of my knowl	edge, death occurre end/or investigation	d at the time, date and place, and in my opinion, death occurred a	28t. LOCATION (Street City or Town, State) due to the cause(s) end mai t the time, date and place, ar	nner as stated, and due to the ceuse(s)	and manner es stated.
BE COMPLETED	2 Accident 3 Suicide 6 Could not be determined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATUTE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO CO	IN: To the best of my knowl On the best of exemination COMPLETED CAUSE OF DEA	edge, death occurred and/or investigation TH (ITEM 27) (Type,	d at the time, date and place, and it, in my opinion, death occured a 29c. LICENSE	28t. LOCATION (Street City or Town, State) due to the cause(s) end me t the time, date and place, an	nner as stated, ad due to the cause(a) 29d. DATE SIGNED (and manner es stated. Month, Day, Year)
BE COMPLETED	2 Accident 3 Suicide 6 Could not be determined 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: 29b. SIGNATUTE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO CO	IN: To the best of my knowl	edge, death occurred and/or investigation TH (ITEM 27) (Type, and a structure)	d at the time, date and place, and in my opinion, death occurred a	28t. LOCATION (Street City or Town, State) due to the cause(s) end me t the time, date and place, an	nner as stated, ad due to the cause(a) 29d. DATE SIGNED (and manner es stated. Month, Day, Year)

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BALTIMORE ,	
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DIVISION OF VITAL RECORDS, P.O. BOX 68760.

		1 - STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIFI	TMENT OF H	HEALTH AND I	MENTAL HYGIEN REG. NO		
		1. DECEDENT'S NAME (First, Middle, Lest) CLYDE	MC KINLEY	Z RE	DD		2. DATE OF DEATH	6 1994	3. TIME OF DEATH 0045 M
P		4. SOCIAL SECURITY NUMBER 217-40-4676	X M 2 F 5	In yrs. lest birthdey) In YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH FEB. 23,	1943	COUNTY ARYLAND
. 2. 3 should	стоя	9a. FACILITY NAME (If not institution, give statements) 2800 block of RESIDENCE OF DECEDENT		ue		more ci		9c. COUNTY (of DEATH
physician. burial-transit permit. Pages 1.	DIRE	10a. STATE 10b. COUNTY MARYLAND	n/a	10c. CITY	BALTI	MORE			10d. INSIDE CITY LINTS? 1 YES 2 NO
an. ransit per	FUNERAL		RTHBOURNE	RD.	101	21239			ED STATES
	B⊀	11, MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 THE TES IF YES, GIVE WAR OR DA	2 NO	if yes, sp	ENDENT OF HISPAN lecify Cuben, Maxica 2 No Specify	IIC ORIGIN? (Specify Yea n, Puarto Rican, atc.)	- 2	RACE — American Indian, Black, White, atc. Specify: BLACK
ital or attending for use as the	LETED	15. DECEDENT'S EDUC (Specify only highest grade of Elamentary/Secondery (0-12)	COllege (1-4 or 5 +)	16a. DECEDENT'S I (Give kind of w life. Do NOT use LABO	ork done during mo retired.)	DN ost of working	16b. KIND OF BUS		
by the hospital be detached to at once.		12 TH 17. FATHER'S NAME (First, Middle, Last)	DEDD	LABO			ME (First, Middle, Maiden	Surname)	THE TAKE
retained by 5 should be notified at	TO BE	MC • KINLEY 19a. INFORMANT'S NAME (Type/Print)	REDD	19b. MAILING			Route Number, City or Town	n, State, Zip Code	
ay be		I.TI.I.TE RED 20a, METHOD OF DISPOSITION 1 ABurial 2 Cremation 3 Remo	20b.	150 PLACE AND DATE OF THE PROPERTY OF THE PROP	F DISPOSITION (Na	ame of		CATION City	
r death. Page te funeral dir al.		21. SIGNATURE OF FUNERAL SERVICE LICE		RRISON	22. NAME A	ND AGORESS OF FA			E. NORTH AV
ectificate be executed within set hours at ling physician and completely filled in by typene prior to burial. cremation. or remother traumatic event, the medic.	CERTIFICATION	IMMEDIATE CAUSE (Finel	DUE TO (OR AS A	ech line.	of In		has cerdiac or reepi	ratory arreat,	Approximate interval Between Onset and Death
v requires that the death of been signed by the attend it, of Health and Mental H shows any Injury, or	MEDICAL	PART II. Other eignificent conditions				16	Part I. 24a. WAS AN PERFOR	IMED?	24b. WERE AUTOPSY FINDINGS AWILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 VES 2 NO
The law ite has b ate Dept.	PHYSICIAN:		HOSPITAL:	26. PLACE OF DEATH] UNCERTAIN	1 🗆 📗		
TE DING PHYSICIAN: The DIA After this certificate death with the State is it marked, or item	ED BY PHYS	27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be detarmined	26a. DATE OF INJURY (Month, Day, Year) 26a. PLACE OF INJURY building, atc. (Speci	28b. TIME INJU 4 003	OF 28c. INJ	URY AT RK? YES 2 NO	28d. OESCRIBE HOW IN 28d. OESCRIBE HOW IN 28l. JOCATION (Street a City or Town, State)	localin	accide
E I IN	OMPLET		IAN: To the best of my knowle I: On the basis of examination		d at he time, date				ENUL Meylas
TO THE HO TO THE Ho be filed	TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER	U. King	_m.D		29c. LICENSE NUM	BEA		NED (Month, Day, Year)
		THEODORE MK	-6	111 Pen		et, Bal	timore.	Maryla	and 21201
10		DFC1 9 1994	32. REGISTRAR'S SIGNA	ATURE					



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL (De filed within 72 h

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HOSPITAL

permit. burial-transit rurs after death. Page 6 may be retained by the hospital or attending physician. the funeral director, page 5 should be detached for use as the notified at þe must medical examiner the attending physician and completely filled in by Mental Hygiene prior to burial, cremation, or remo the event, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with traumatic or other I Realth and I shows any serificate has been s th the State Dept. of H 23 Item 6 marked, with This DIRECTOR: A hours after d 28 item

37454 9 [1 Item#22 Per F.H. Film# G-718 12/19/94 R.M. FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH P ROBINSON JOHN H 8.20 94 12 12 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, You) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 217012642 MONTHS DAYS HOURS 1 M 2 F 80 12 YRS. 29 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 2330 W. LEXINGTON STR HOME -DIRECTOR BALTO BALTIMORE, CIT RESIDENCE OF DECEDENT STATE / 10b. COUNTY OC. CITY, TOWN OR LOCATION 10d. INSIDE CITY more 1 TYES 2 NO FUNERAL 10a, STREET AND NUMBER 101. ZIP CODE 16a, CITIZEN DE WHAT COUNTRY? 33 na 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 V YES 2 NO 11. MARITAL STATUS 13. WAS DECENOENT DF HISPANIC ORIGIN? (Specify Yee or No-RACE — American Indier Black, White, etc. 1 Never Merried 2 Merried If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 ND Specify: YES, GIVE WAR OR DATES В 3 Widowed 4 Divorced COMPLETED 15. DECEOENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) Coffege (1-4 or 5+) P nanic EATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle eev H 19b. MAILIND ADDRESS (Stre et end Number or Rural Route 9 neva 20a. METHOD OF DISPOSITION

1 M Buriet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Na OATE 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY om Ball 23. PAPTI. Enter the disesses, or complications that ceused the death. Do not enter the mode of dying, auch as cardiac or respiratory arrest, abock, or heart feliure. List only one cause on each line. Approximata IMMEDIATE CAUSE (Fine) Onset and Death disesse or condition RECTAL CARLINOMA WILL METASTASES resulting in death) OUE TO (OR AS A CONSEDUENCE DF): CERTIFICATION Sequentielly list conditions, OUE TO (OR AS A CONSEDUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in desth) LAST PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO ASCUD well Carelica Arregthina COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES \(\Boxed{1}\) NO \(\boxed{1}\) UNCERTAIN \(\Boxed{1}\) PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE DF DEATH (Check only one) OTHER: 1 YES 2 NO 1 Inpetient 2 ER/Outpatient 3 DOA ng Home 5 (1) Residence 6 (a) Other (Specify) FRIENDS HOUSE 27. MANNER OF OEATH 26e. DATE DF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c, INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending м 1 YES 2 ND BY 2 Accident 26e. PLACE DF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 26t. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. (Check only one) 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner ee stated.



LINDEN

ETED CAUSE DF DEATH (ITEM 27) (Type, Print)

BALTO

MD

AVE

29b. SIGNATURE AND TITLE OF CERTIFIER

30. NAME AND ADDRESS OF PERSON W

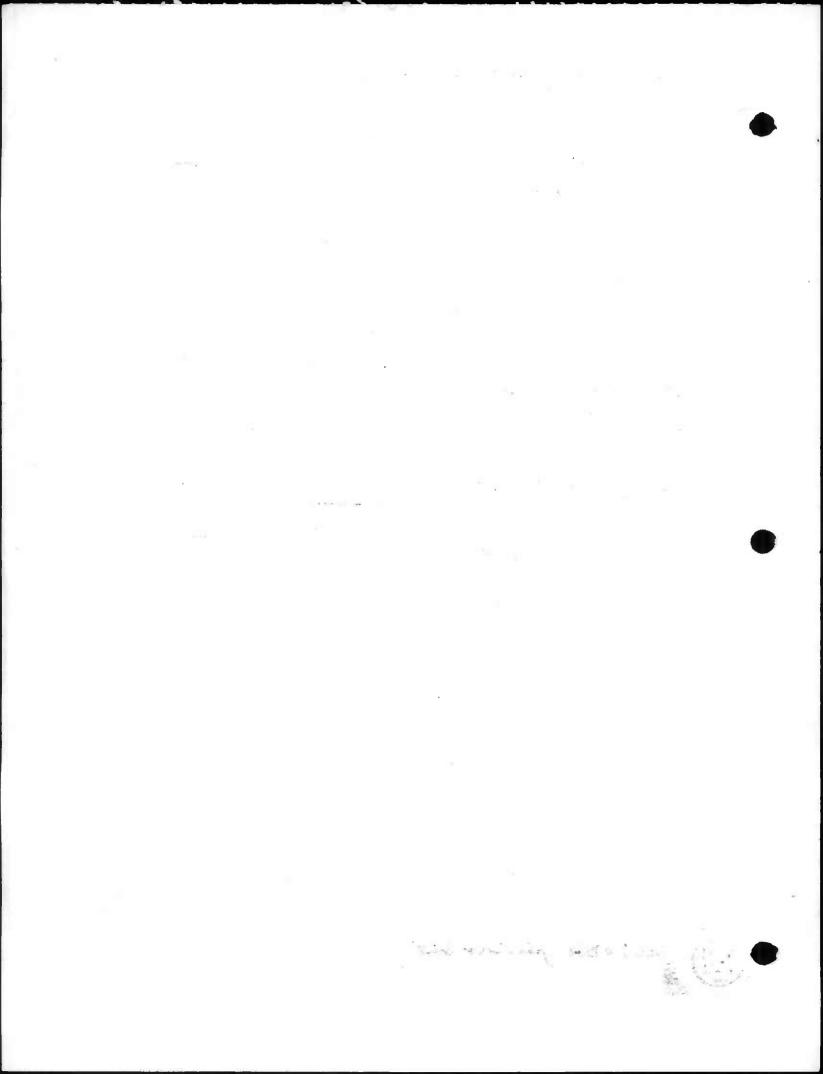
29d. DATE SIGNED (Month, Day, Year)

16/94

12/

29c. LICENSE NUMBER

21201



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 5. SE) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 1 M 2 🗆 F DAYS HOURS YAS Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEAT DIRECTOR imore RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD 1 TYPES 2 NO Baltimore permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1015 N. Payson St. funeral director, page 5 should be detached for use as the burial-transit 21217 IISA Page 6 may be retained by the hospital or attending physician. 11 MARITAL STATUS 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, OIVE WAR OR DATES 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. BALTIMORE. MARYLAND 21215-0020 1 Never Married 2 Merried If yes, specify Cuben, Mexicen, Puerto Rican, stc.) 1 YES 2 NO Specify: BY 3 Widowed 4 Divorced Black COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complete 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5 +) Systems Analyst Self Employed 17. FATNER'S NAME (First, Middle, Last) 18, MOTNER'S NAME (First, Middle, Maiden Surneme) Thomas H. Ross, Sr. notified at Alethia Fields BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Carolyn Ross 1015 N. Payson St. Balto., MD pe 20e. METHOD OF DISPOSITION
1 ☐ Buriet 2/100 Cremetion 3 ☐ Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Metro Crematory or other plece) 4 Donation 5 Other (Specify) Catonsville, 21. MONATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY hours after death. James A. Morton & Sons Funeral Hom 1701 Laurens St the medical 23. PART I Liter the diseases, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, filled in by t ek, Dr heart failure. List Dnly Dne Interval Between ò IMMEDIATE CAUSE (Final Onaet and Daeth the IMMUN ODEFICIENCY LYNDRONE disease or condition ACQUIRED completely reaulting in death) executed within event. DUE TO (OR AS A CONSEQUENCE OF) and com o burial, traumatic CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF 9 If any, leading to immediate cause. Enter UNDERLYING been signed by the attending physician it, of Health and Mental Hygiene prior to requires that the death certificate be other t CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 0 DIMISION OF VITAL RECORDS, PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? shows any 1 TYES 2 T NO 1 YES 2 NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES IN NO UNCERTAIN PHYSICIAN: has be Dept. AH ATTENDING PHYSICIAN: The law 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem r this certificate h HOSPITAL 1 YES 2 NO OTHER 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Offureing Home 5 - Residence 8 - Other (Specify) 07 27. MANNER OF DEATN 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT 28d, DESCRIBE NOW INJURY OCCURED marked, 1 Antural 1 YES 2 NO After t BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 69 3 Sulcide 281, LOCATION (Street and Number or Rural Route Number FUNCE TO HOURS AFER O ED 8 Could not be 4 Homicide 28 COMPLET 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end piece, end due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the base of examination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the cause(s) end menner se stated. 296 SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 2907/ 29d. DATE SIGNED (Month, Day, E 6 6 8 M BE 0 PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) N. EUTAW ST #305 BALTIMORE MD 2120 NAN



•	FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL CERTIFICATE OF DEATH	HYGIENE REG. NO.
			1160. 140.

	1 - REGISTRAR	CERTIFI	CATE OF D	EATH	REG. NO.	-	
- 3	1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH
	Seth Smith				MONTH DA		7550 M
	4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In)	rrs. last birtnday)	IF UNDER 1 YEAR	UNDER 24 HRS.	7. DATE OF BIRTH		HPLACE (State or Foreign
- 9	244-20-5985 18M20F 7	7 YRS.	ONTHS DAYS H	oune Min.	(Month, Day, Year)	Count	CAROLINA
	9e. FACILITY NAME (If not institution, give street end number)		9b. CITY, TOWN OR L	OCATION OF DE		9c. COUNTY OF C	
Œ	Harford Gardens NS9 Con				A111	mr	
DIRECTOR	RESIDENCE OF DECEDENT	ter	Balt	Ο,			,
Ä	10s. STATE 10b. COUNTY	10c. CITY,	TOWN OR LOCATION				10d. INSIDE CITY
5	MARYLAND n/a		BALT	IMORE			TOUR INSIDE CITY
	10e. STREET AND NUMBER		10f. ZN	CODE		10g. CITIZEN OF	
H.	1300 LANVALE STREET			21213		UNITE	D STATES
FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U	S. ARMED	13 WAS DECENS	ENT OF HISDAN	IC ORIGIN? (Specify Yes	22 No. 14 B4C	E — Americen Indien,
	1 Never Merried 2 Merried FORCES? 1 YES	2 X NO	If yee, specify	Cuben, Mexice	n, Puarto Rican, atc.)	Blec	k, White, etc.
B	3 Wildowed 4 Divorced	:5	1 TYES 2 [NO Specify	7.	Spec	BLACK
	15. OECEDENT'S EDUCATION 16	Sa. OECEDENT'S U	SUAL OCCUPATION		16b. KIND OF BUS	INESS/INDUSTRY	
	(Specify only highest grade completed) Elementapy/Secondacy, (0-12) College (1-4 or 5 +)	life. Do NOT use		working			
4	Elementary/Secondary (0-12) College (1-4 or 5+)	HOUSE	KEEPER		CHUF	CH HOM	E HOSPITAL
COMPLETED	17. FATHER'S NAME (First, Middle, Last)		18	MOTHER'S NA	ME (First, Middle, Maiden	Sumamal	
	OSBORN SMITH			LIV			
B	19e. INFORMANT'S NAME (Type/Print)	19b. MAILING A	ODRESS (Street and I	lumber or Rural F	Route Number, City or Town	State Zin Codel	
임	MAYBELL STEVENSON	201			TON ST, E		RE,MD#31
	20s. METHOD OF DISPOSITION 20b. BI		DISPOSITION (Name of			CATION — City or To	
- 1			MORIAL	PARK			STOWN, MD
- 1	21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND A				
	D 20 1/10 1					3. E 37	ODELL AVE
	Tel bolland						ORTH AVE.
- 1	23. PART I. Enfer the diseases, or complications that caused the shock, or haert fallura. List only one cause on each	ne deeth. Do no	t enter the mode	of dying, sucl	as cardlec or respin	ratory arrest,	Approximate
	IMMEDIATE CAUSE (Finel	i iii ea.					Interval Between Onset and Daath
-]	disease or condition a. Callral woo	homia					
	DUE TO (OR AS A CO	ONSEQUENCE OF)					
z	Cerebrovaccu	landic	RADRI				
CERTIFICATION	If any, leading to immediate						
<u>ა</u>	CAUSE (Disease or injury						
늗	that initiated events DUE TO (OR AS A CO	ONSEQUENCE OF):					
E	resulting In deeth) LAST						
- 11	PART II. Other significant conditions contributing to death but	not resulting in	the underlying or	use alven in	Pert i. 24a. WAS AN	ALTTORON TOU	WETT AUTORAL FARMING
DICAL	Protein energy malnutrition		tha underlying ce	use given in	PERFOR		WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO
ă					1 _ YES 2	1 NO	COMPLETION OF CAUSE OF DEATH?
Σ	Vacular domentia				_		1 TYES 2 NO
Ż	DID TOBACCO USE CONTRIBUTE TO CAUSE OF	DEATH YES		UNCERTAIN	1 🗆 📗		
ਹੋ		PLACE OF OEATH					
Z	EXAMINER? 1 VES 2 NO NO HOSPITAL: 10 Impatient 2 ER/Outpate	ent 3 🗆 DOA	Nursing Home 5	Raeldence	8 Other (Specify)		
PHYSICIAN: ME	27. MANNER OF OEATH 28e. OATE OF INJURY (Month, Day, Year)	28b. TIME		AT	28d. DESCRIBE HOW IN	JURY OCCURED	
à	1 Natural 5 Pending 2 Accident investigation			2 🗌 NO			
	3 Suicide 8 Could not be 28e. PLACE OF INJURY — building, atc. (Specify)	At home, farm, str	eet, factory, offica		28f. LOCATION (Street as City or Town, Stete)	nd Number or Rural I	Route Number,
H	4 Homicide detarmined				, , , , , , , , , , , , , , , , , , , ,		
ا ۲	29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge)	ge, death occurred	at the lime, date and	place, and due	to the cause(e) end men	ner as stated.	
COMPLETED	one) 2 MEDICAL EXAMINER: On the basis of examination as						a) end menner ee stated.
- 11	29b. SIGNATURE AND TITLE OF CERTIFIER						
	Conston mis		29	C. LICENSE NUM	4.0	29d. DATE SIGNED	(Month, Day, Year)
일	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH	//TEM 27 /3	l l	0284	004	/	04/15/11
	J Boston Union 1	Jemor In	Durais	m of	Seriatrie	RAndini	
			L DIVISIO	III CT	Jerranie	MECHON	٧.
	31. DATE FILEO (Month. Day her) DEUT 9 1994 Julia d'Author 1994	II;					

L.R.B.

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-718 12/19/94 t.t.

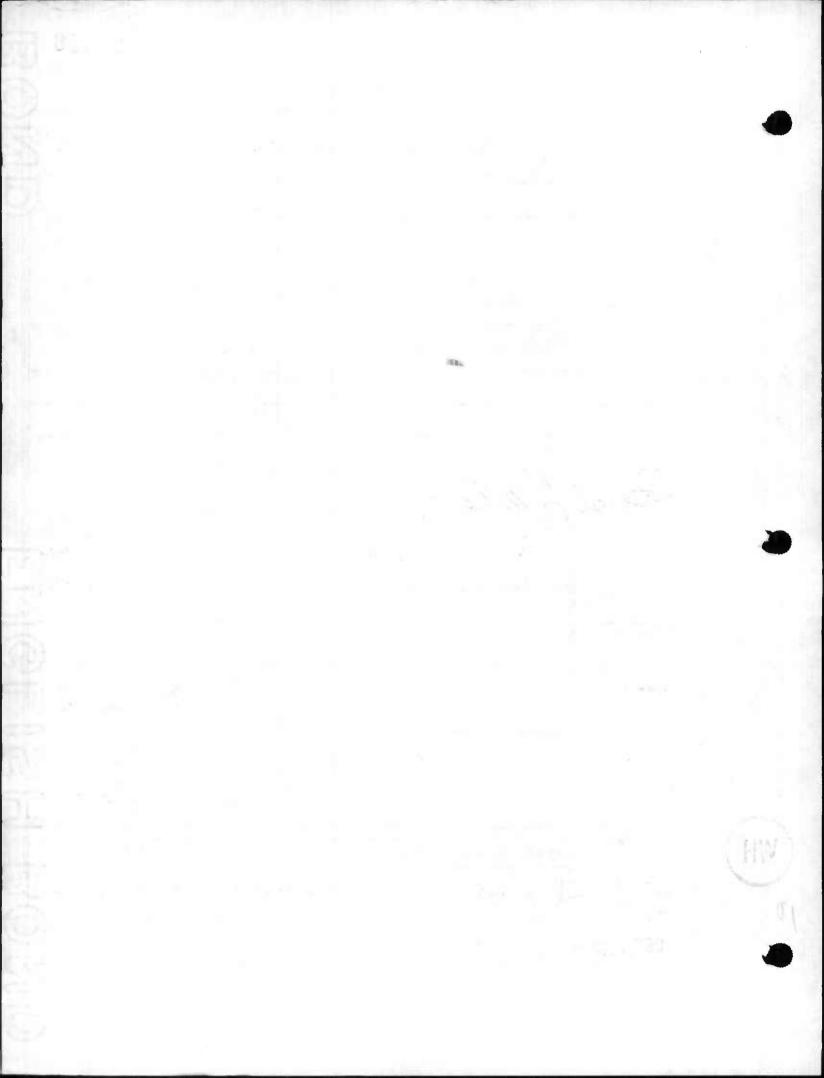
	1 - STATE REGISTRAR	STATE OF MARY		TMENT OF I		MENTAL HYGIENI REG. NO.	E	
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN	N O O A YEA	3. TIME OF DEATH
	CATHERINE 4. SOCIAL SECURITY NUMBER	I a any		SWEE	1	NOV 28 ™		3:36P M
		5. SEX 8. AG	E (In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year)	0	BIRTNPLACE (State or Foreign Country)
	9a. FACILITY NAME (If not institution, give s	X		9b. CITY, TOWN	OR LOCATION OF DE	11-24-25	9c. COUNTY	C OF DEATN
OR	700 BLK OF N.	HILTON P	KWY.	Balti	more Ci	ty.		
DIRECTOR	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY	(10c. CIT	Y, TOWN OR LOCA	TION			10d. INSIDE CITY
	MARYLAND		BAI	TIMORE				LIMITS?
FUNERAL	10e. STREET AND NUMBER				1. ZIP CODE		10g. CITIZEN	OF WHAT COUNTRY?
JNE	2900 W. LAFAYE	TTE AVE.	INUS ARMED	13 WAS DE	21216	IIC ORIGIN? (Specify Yes	US	RACE — American Indian,
ВУ	1 Never Married 2 Married 3 Widowed 4 Divorced	FORCES? 1 YES	S 2 NO	If yes, s	ecify Cuben, Maxica 2 X NO Specify	n, Puerto Rican, atc.)	1 1	Black, White, atc. Specify: BLACK
ED	15. DECEDENT'S EDUC (Specify only highest grade		(Give kind of t	USUAL OCCUPATI	ON osl of working	18b. KIND OF BUS	INESS/INOUSTI	
J.E	Elementery/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT us	te retired.)		1		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)		DOMEST	LCIAN	18. MOTNER'S NA	ME (First, Middle, Meiden S	Surname)	
BE C	HERBERT CHA	VOUS				JINE M.	,	
TO B	19a. INFORMANT'S NAME (Type/Print)		1			Route Number, City or Town		
,	DEBORAH CLAXT		1817			PE. BALTO	MD CATION - City	
	1 Burial 2 Cremetion 3 Reme 4 Donation 5 Other (Specify)	oval from State Co	emetery cremetory or o	ther niecel		1	•	COUNTY, VA
	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE		22. NAME A	NO ADDRESS OF FA	CILITY		SOUNTIFUN
,	I Sunwal &	Kern						N.MONROE ST
	25. PART I. Enter the diseases, or cenock, or heert fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in death)	s. MULTIPLE IN	eech line.		ode of dylng, suc	h es cerdiec or respir	etory srrest,	Approximate Interval Between Onset and Death
CERTIFICATION	Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST	c	A CONSEQUENCE OF					
CALC	PART II. Other significent condition	e contributing to death	but not resulting	n the underlyin	g ceuse given in			24b. WERE AUTOPSY FINDINGS
PHYSICIAN: MEDICA						PERFORI		AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
N.	DID TOBACCO USE CONTE	RIBUTE TO CAUSE				V 🗆		
SICU	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1X XYES 2 □ NO	HOSPITAL:	26. PLACE OF DEAT	OTHER:		. D/	ב אולים א	7
Ä K	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	7 28b, TIM	E OF 28c. IN.	URY AT	28d. DESCRIBE NOW IN		PDRIVEP IN PICK-
ВУ	1 Natural 5 Pending 2 XX Accident Investigation	11-28-94	3:25	P M 1 🗆	YES 2XX NO	UP TRUCK/ TRU		
	3 Suicide 8 Could not be 4 Homicide determined	28a. PLACE OF INJUF building, atc. (Sp	RY — At home, farm, a secify) ROADW		•	281. LOCATION (Street as City or Town, State) PARKWAY, BAL	700 BLK.	NORTH HILTON
COMPLETED		CIAN: To the beat of my kno R: On the baels of examinat						use(s) and manner as stated.
TO BE C	299 SIGNATURE AND TITLE OF CERTIFIER	Shell			O . C . M		29d. DATE SIG	29, 1994
	HAMBRUS AL	47.60 00 1.17	11 Penn		, Balti	more, Ma	ryland	1 21201.
	DEC 1 9 1994	32. REGISTRAR'S SIG						

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020
As after death. Page 6 may be retained by the hospital or attending physician.

KISION OF VITAL RECORDS, P.O. BOX 68760, ATENDING PHYSICIAN: The law requires that the death certificate be executed within Carre

	1. DECEDENT'S	RAR S NAME (First, Middle, La	et)		CERTIFIC	OAIL O	DLA	2,1	REG. NO		3	3. TIME OF DEA
1	Jose		Saboy					D	ecember .	16 19	54	9:00
	4. SOCIAL SEC	CURITY NUMBER	5. SEX	6. AGE (In yr	rs. lest birthday)	IF UNDER 1 YEAR	-	-	DATE OF BIRTH (Month, Day, Year)		, BIRTHPL Country)	LACE (State or F
	218-24	4–9184	1 M 2 □ F	64	YRS.	MONTHS DAYS	HOURS		ine 19 19	930 M	fary1	_
		NAME (If not institution, gir	ve street end number)			9b. CITY, TOWN				9c. COUNT	Y OF DEA	АТН
OR		n Hospital				Baltin	nore					
E	RESIDENC 10e. STATE	E OF DECEDENT			10c. CITY,	TOWN OR LOC	CATION				1	10d. INSIDE CITY
DIRECTOR	Maryla	nd			Ba1	Ltimore	į.					LIMITS?
	10e. STREET A						10f, ZIP CODE	E		10g. CITIZE		IAT COUNTRY?
ERAL	251 S.	. Durham S	treet				21	231		USA		
FUN	11. MARITAL S		12. WAS DECEDEN	NT EVER IN U.S					PRIGIN? (Specify Yes	s or No- 1	4. RACE -	- American Indi White, etc.
BY F		nrried 2 🌠 Merried		WAR OR DATES			ES 2 X NO		io. tricell, etc.)		Specify:	
ED B		15. DECEDENT'S 8	DUCATION	146	a, DECEDENT'S U	ISTINI OCCUPA	TION		16b. KIND OF BU	SINESS (IND.)	RTRY	MITTE
ETE	Flamour	(Specify only highest gr			(Give kind of w. life. Do NOT use	ork done during in retired.)	most of working	ng	MITE OF BU	UU	J 1188	
IPLI	10th	. Jeogrammy (U-12)	S 10 P-1) volume	"		horeman			Shippin	ng		
COMPL		NAME (First, Middle, Last)					18. MOTI		First, Middle, Maiden			
BE C	George		Saboy				Ca	therin	ne	U	Inkno	own
TO B		NT'S NAME (Type/Print)							Number, City or Tox			
=		W. Saboy						Balti	more, Ma			
		OF DISPOSITION	temoval from State	of ceme	LACE AND DATE	or other place)				OCATION — CI		
	4 Donation	5 Other (Specify)			y Rosar	y Cemet			12/19 Ba	1timor	e, M	Marylan
	21. SIGNATURE	E OF FUNERAL SERVICE	LICENSEE	11	1	David	J. W	eber F	uneral H	Home		212
	10	livel.	A M	11/2	1	1404 -						
		Enter the disesses, shock, or heert fellu							t. Balt			Approxim
_	1	shock, or heert fellu CAUSE (Finel condition	e. DUE TO	O (OR AS A CO	MOTO	ot enter the n						Approxim
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BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

THE HURRAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within software death. Page 6 may be retained by the hospital or attending physician.

The FUNERAL ORECTOR: After this certificate has been signed by the attending physician and completely fleed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760

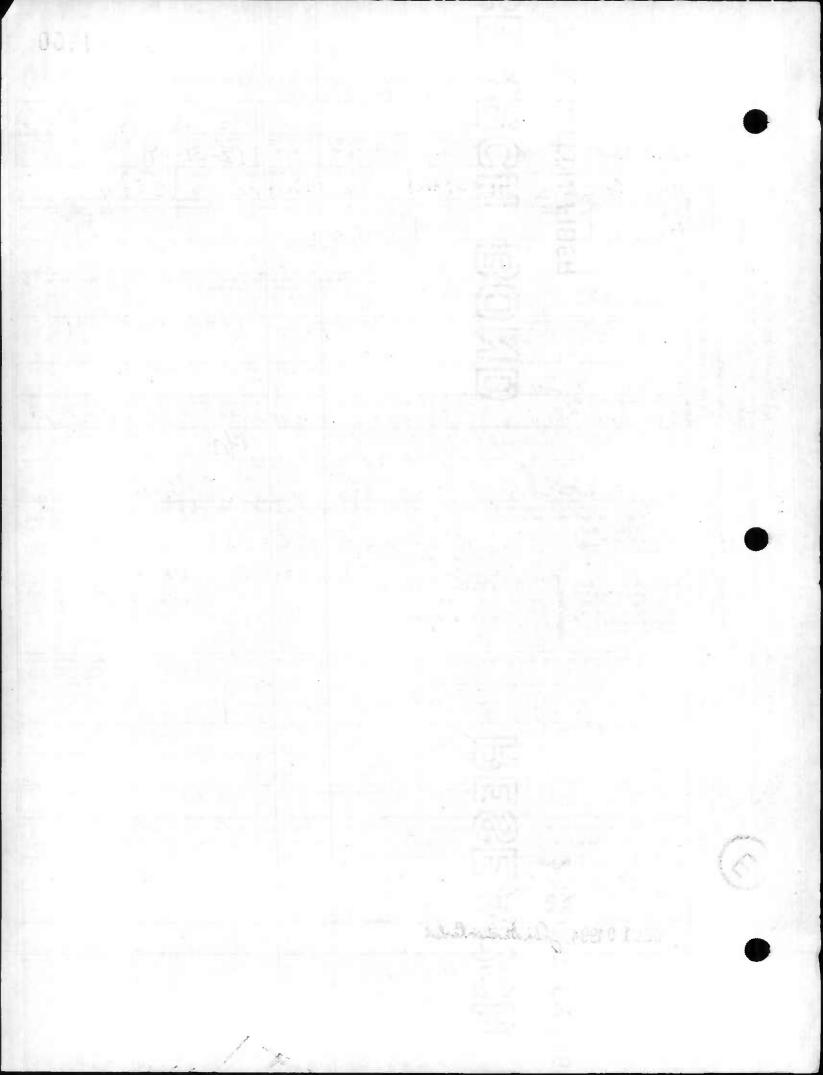
FOR 1 - STATE REGISTRAR			ID / DEPAR	TMENT OF	HEALTH A	ND MEN	TAL HYGIEN		
1. DECEDENT'S NAME (First, Middle, Last)				-			ATE OF DEATH		3. TIME OF DEATN
Joan	Lois		STA	ALEY			cember		994 12:30 am
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In)	rrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24	HRS. 7. D/	TE OF BIRTH	Ī	6. RIPTNPI ACE (State or Foreign
215-30-3117 90. FACILITY NAME (If not institution, give s	1 M 2 X F	62	YRS.	MONTHS DAYS	Cacalica	0.	fonth, Day, Year) 1/05/193		Maryladnd AND
Franklin Square		1		96. CITY, TOWN	SVille				timore
RESIDENCE OF DECEDENT								Dal	LIMOre
10m. STATE 10b. COUNTY Maryland	Baltimo	re	10c. CIT	Y, TOWN OR LOC		sville	e		10d. INSIDE CITY LIMITS? 1 Yes 2 NO
10e. STREET AND NUMBER				1	of. ZIP CODE			10g. CITIZ	ZEN OF WHAT COUNTRY?
15 Paula Place A						21237			nited States
1 Never Married 2 Married	12. WAS DECEDED FORCES?	YES :	2 X NO	13. WAS DE	CENDENT OF I specify Cuben, I	HSPANIC OR Maxican, Pus	IGIN? (Specify Yes rto Rican, atc.)	or No-	14. RACE — American Indien, Black, White, atc.
3 Widowed 4 Divorced	IF YES, GIVE V	VAR OR DATE	S		S 2 KNO		200000000000000000000000000000000000000		Specify: White
15. OECEDENT'S EDU (Specify only highest grade	CATION completed)	16	(Give kind of v	USUAL OCCUPAT	ION nost of working		16b, KIND OF BUS	SINESS/IND	USTRY
Elementary/Secondary (0-12)	College (1-4 or 5	+)	life. Do NOT us	se retired.)		- 1			
12 Years			Secret	ary			Cleri		
17. FATHER'S NAME (First, Middle, Last)							st, Middle, Maiden	Surname)	11-0
John Weidner 19a. INFORMANT'S NAME (Type/Print)						Sahm			
Ms Carol Founta	in						lumber, City or Town		
20g. METHOD OF DISPOSITION	TII	205 81		Chesac of Disposition (-			ryland 21237
1X Burial 2 Cremetion 3 Remo	oval from Stata	cemete.	ry, crematory or of	ther place) Pk.	1 2 /1 0	101	DATE 20c. LO		City or Town, State
21. SIGNATURE OF FORERAL SERVICE LIC	ENSEE	MOTE	STATIC M	22. NAME	AND ADDRESS	0F FACILITY	Pa	irkvi.	lle, MD
Who s	26)	2					ral Home	e of I	Dundalk, Inc.
Allgan (- Vees	_		792	2 Wise	Ave.	Dunda1	k, M	D 21222
23. PART I. Enter the diseases or of the state of the sta	complications the List only one car	t ceused the	na death. Do r n line.	ot anter the m	oda of dying	, auch aa c	ardiac or reapl	ratory arre	eat, Approximata Interval Between
IMMEDIATE CAUSE (Finel									Onaat and Death
disease or condition reaulting in death)	Cardio				:				HOR
			NSEQUENCE OF	,					
Sequentially list conditiona,	D,		CATCINO	ma live	r				1 MONTH
if any, leading to immediate cause. Enter UNDERLYING	Breast			,.					
CAUSE (Diseese or Injury that initiated eventa			INSEQUENCE OF	ŋ:					3 years
resulting in deeth) LAST	4								
DATE II Other should not a see that							_		
PART il. Other significant condition	e contributing to	deeth but	not resulting i	n the underlyi	ng cause give	en in Part I	. 24s. WAS AN PERFOR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
							1 TYES 2	™ NO	OF DEATH?
DID TODA 4440 MICT 440 MICT				. =					1 TYES 2 NO
DID TOBACCO USE CONTI	KIBUIE IO CA					TAIN			
EXAMINER?	HOSPITAL:			N (Check only one OTHER:					
27. MANNER OF DEATN	1X Inpetient 2 28a. DATE OF		nt 3 DOA	4 Nursing Ho	me 5 - Reside				
1 Natural 5 Pending	(Month, E			URY	ORK?		DESCRIBE NOW IF	NJUNY OCC	UNED
2 Accident Investigation 3 Suicide & Could get be	28a. PLACE C	F INJURY —	At home, farm, a	treet, factory, off		-	OCATION (Street o	and Alexandras	or Rural Route Number,
4 Nomicide 6 Could not be	building,	atc. (Specify)		,,,		201. 6	City or Town, State)	no number c	or nurer noute number,
29a. CERTIFIER	CIANI To the best of	and the state of						-	
(Check only one) 1 CERTIFYING PHYSII MEDICAL EXAMINE									od. • cause(a) end menner as atated.
29b. SIGNATURE AND TITLE OF CERTIFIER		_	1	/	29c. LICENS	E NUMBER.	T	29d. DATE	SIGNED (Month, Day, Year)
	Jan	~pa	1 pe	01	D	16/1	63	•	
30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAU	SE OF DEATH	(ITEM 27) (Type,	Print)		-			
Dr. Sompalli Prasa	ad M.D.	9000 F	rankli	Square	e Drive	e Balt	timore M	íarv1a	and 21237
Dr. Sompalli Pras: OEC 19 1994	ala diwale	INTRAMENDED IN THE	24					- 1 - P.M.	

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BALTIMORE, MARYLA	retainer
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, P.O. BOX 68760,	eath certificate be executed with
OS, P.O. BOX 68760,	he death certificate be executed with
RDS, P.O. BOX 68760,	it the death certificate be executed with
CORDS, P.O. BOX 68760,	res that the death certificate be executed with cours after death. Page 6 may be retained by thy

STAT	E OF MARYLAND	/ DEPARTMENT	OF HEALTH	AND MENTAL	HYGIENE
		CERTIFICATE	OF DEAT	TH	REG. NO.

	REGISTRAR	OINTE OF MINITE	AND / DEPARTMENT OF	OF DEATH	REG. N		/
	1. DECEDENT'S NAME (First, Middle, La	SMALL			2. DATE OF DEATH	DAY 9	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 215 66 048		In yrs. lest birthdey) IF UNDER 1 YRS. MONTHS D.	EAR IF UNDER 24 HRS. AYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		BIRTHPLACE (State or Foreign Country)
CTOR	98. FACILITY NAME (If not institution, git Bon Sc Cour RESIDENCE OF DECEDENT	11 - 04	tel Bc	OWN OR LOCATION OF D		9c. COUNTY	OF DEATH
DIRE	100. STATE 10b. COU	INTY	Baltin	nore.			10d, INSIDE CITY LIMITS? 1 YES 2 NO
IERAL	1817 West M	oshen Str	eet	101, ZIP CODE 21214	7	10g. CITIZEN	OF WHAT COUNTRY?
BY FUN	1 Never Merried 2 Married 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 NO If y	S DECENDENT OF HISPA es, specify Cuban, Maxic YES 2 NO Speci	an, Puarto Rican, etc.)	Yes or No- 14.	. RACE — American Indian, Black, White, etc. Specify CCC
IPLETED	15. DECEDENT'S E (Specify only highest gi		16a. DECEDENT'S USUAL OCCU (Give kind of work done durly life. Do NOT use retired.)	JPATION ng most of working	16b. KIND OF E	BUSINESS/INDUS	TRY
E COMPL	17. FATHER'S NAME (First, Middle, Last) Benny	Small		16. MOTHER'S N	AME (First, Middle, Meid	len Sumame)	
TO B	DON'T SOM	911	19b. MAILING ADDRESS (S	mosher and Number of Rural	Aoute Number, City or 1	own, State, Zip Co	Md 21217
	20e, METHOD OF DISPOSITION 1		PLACE AND DATE OF DISPOSITION (Property Crematory of other place)	tem.	1412 7	Balto,	y or Town, Stata
	21. SIGNATURE OF FUNERAL SERVICE	LICENSEE A. P.	22. NAI	SCPN L	RUSS	finer	al Hm
	23. PART I/Enter the diseases,	or complications that caused	1 the death. Do not enter the	e mode of dying, aud	orth au,	Ballo apiratory arrest	Md 2/2/6
CERTIFICATION	23. PART I Enter the diseases, shock, or heart feliu iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	e. REJ (PL DUE TO (OR AS A DUE TO (OR AS A	I the death. Do not enter the ach line. RETORY CONSEQUENCE OF): CONSEQUENCE OF):	ARR	EST		interval Between Onset and Dasth
MEDICAL CERTIF	immediate cause (Finel disesse or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events	e. REJ (Pi DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A d.	ACONSEQUENCE OF):	ARR	Part I. 24a, WAS		interval Between Onset and Dasth
MEDICAL CERTIF	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions, if any, seading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions, if any seading in death is a significant condition.	b. DUE TO (OR AS A DUE TO (OR AS A d. DUE TO HOR AS A d. DUE TO HOR AS A d. DUE TO HOR AS A d. DUE TO HOR AS A d. DUE TO HOSPITAL:	ACONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): OTHER:	ARR	Part I. 24a. WAS PERF	UNG NEG	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
SICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II, Other significent conditions are summediated events. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH	b. DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A	ach line. ROTORY CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF): CONSEQUENCE OF):	CVCT(V	Part I. 24a. WAS PERF	AN AUTOPSY FORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions and in the initiated events resulting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not	b. DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A d. tions contributing to deeth be limited by the contribution of the contribution	ach line. RATORY CONSEQUENCE OF):	Tryling ceuse given in 26. PLACE OF DEATH (C) 19 Home 5 Rasidence 10. INJURY AT WORK? 1 YES 2 NO	Part I. 24a. WAS PERF 1 YES	AN AUTOPSY ORMED? 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ETED BY PHYSICIAN: MEDICAL CERTIF	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions in death LAST 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNED OF DEATH 1 Netural 5 Pending Investigated a Suicide B Could not detarmine Check only 1 CERTIFYING PROCESSION CONTROL OF THE PROCESSION OF THE COULD NOT THE COULD NOT THE PROCESSION OF THE COULD NOT THE	DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (O	ach line. RATORY CONSEQUENCE OF): CONSEQUENCE	TVCT(V artyling ceuse given in 26. PLACE OF DEATH (C) 26. HATE OF DEATH (C) 26. HINJURY AT WORK? 1 YES 2 NO 3. office	Part I. 24a. WAS PERF 1 YES 1 Other (Specify) 28d. DESCRIBE HOT City or Town, Ste a to the cause(a) and a	AN AUTOPSY CORMED? 2 NO W INJURY OCCUP of and Number or lite)	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
ED BY PHYSICIAN: MEDICAL CERTIFI	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent conditions in death LAST 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNED OF DEATH 1 Netural 5 Pending Investigated a Suicide B Could not detarmine Check only 1 CERTIFYING PROCESSION CONTROL OF THE PROCESSION OF THE COULD NOT THE COULD NOT THE PROCESSION OF THE COULD NOT THE	b. DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A d. DUE TO (OR AS A d. Litons contributing to deeth be alian to the contributing to deeth be alian to the contributing to deeth be alian to the contributing to deeth be alian to the contributing to deeth be alian to the contributing to deeth be alian to the contributing to deeth be alian to the contributing to deeth be alian to the contributing to deeth be alian to the contributing to deeth be alian to the contributing to deeth be alian to the contribution to t	ach line. RATORY CONSEQUENCE OF): CONSEQUENCE	TVCT(V artyling ceuse given in 26. PLACE OF DEATH (C) 26. HATE OF DEATH (C) 26. HINJURY AT WORK? 1 YES 2 NO 3. office	Part I. 24a. WAS PERF 1 YES 1 Other (Specify) 28d. DESCRIBE HOT 281. LOCATION (Stre City or Rown, Sta	AN AUTOPSY CORMED? 2 NO N INJURY OCCUP et and Number or itel) menner as stated, and due to the c	Interval Between Onset and Dasth 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO



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TO THE HOSPITAL DR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 2x hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

Defined within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal.

FOR	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL H	IYGIENE
REGISTRAR	CERTIFICATE OF DEATH	REG. NO.

	1 - STATE OF MARYLAND REGISTRAR	/ DEPARTM			MENTAL HYGIE		
	1. DECEDENT'S NAME (First, Middle, Last) Max Herbert Shaffer				2. DATE OF DEATH MONTH Dec. 13.	1994 YEA	3. TIME OF DEATH
	4. SOCIAL SECURITY NUMBER 232 22 3681 5. SEX 6. AGE (In yrs. 73	YRS, MON	UNDER 1 YEAR	IF UNDER 24 HRS. HOURE MIN.	7. DATE OF BIRTH (Month, Day, Year) May 1, 1	8. Bi	ountry) St Virginia
TOR	98. FACILITY NAME (If not institution, give street and number) 51 Tranverse Ave. RESIDENCE OF DECEDENT	96.		ddle Riv		9c. COUNTY O	of DEATH Ltimore
DIRECTOR	100. STATE 10b. COUNTY Maryland Baltimore	10c. CITY, TO	WN OR LOCATE	on e River			10d. INSIDE CITY LIMITS? 1 YES 2 NO
FUNERAL	10. STREET AND NUMBER 51 Tranverse Ave.		101.	ZIP CODE 21220			DE WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EYER IN U.S., FORCES? 1 Syres 2 FYES, GIVE WAR OR DATES	ARMED NO	If yes, spe	ENDENT OF HISPAN city Cuban, Maxica 2 NO Specify	IIC ORIGIN? (Specify) n, Puerto Rican, atc.)	50 00 No. 44 B	ACE — American Indian, Hack, White, atc. pecify: White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	DECEDENT'S USU. (Give kind of work ife. Do NOT use reti	done during mos	t of working		usiness/industr	
	17. FATHER'S NAME (First, Middle, Last) Milton Shaffer	11002	160111		ME (First, Middle, Maide		Dept. OI At
TO BE	19e. INFORMANT'S NAME (Type/Print) Wayne Shaffer	196. MAILING ADD 9926	Britti	nay Lan	Route Number City or R	wn, Stere, Zip Coole	21234
	20e. METHOD OF DISPOSITION 1 The Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	EAND DATE OF DE	sposition/Nar Paith	ne of	12/16/94	ocation — city o Baltim	r Town, State
	21. SIGNATURE FUNERAL SERVICE LICENSEE		Bruzd		uneral Ho		, MD 21221
	23. PART I. Enter the diseasee, or complications that caused the ehock, or heart fellure. List only one cause on each list IMMEDIATE CAUSE (Final disease or condition resulting in deeth) DUE TO (OR AS A CONS	Somo	enter the mod	le of dying, such	as cardlec or rea	piretory erreet,	Approximate interval Batween Onset and Death
CERTIFICATION	Sequentially liet conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST						
AL	PART II. Other significent conditions contributing to deeth but not	t resulting in th	e underlying	ceuse given in	Part I. 24a. WAS A PERF(PRMED?	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE	ATH YES [UNCERTAIN	10		1 TYES 2 1 100
IYSIC	EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpatient 27. MANNER OF DEATH 200. DATE OF INJURY	ОТ	HER: Nursing Home		6 Other (Specify)		
BY PI	1 Netural 5 Pending (Month, Day, Year) 2 Accident Investigation	INJURY		IK?	2ed. DESCRIBE HOW		
ETED	3 Suicide a Could not be detarmined 28e. PLACE OF INJURY — At I building, atc. (Specify)	ome, term, street	, tactory, office		26f. LOCATION (Stree City or Town, State		ral Route Number,
COMPLETED	29e. CERTIFIER (Check only one) 1 FERTIFYING PHYSICIAN: To the best of my knowledge, one) 2 MEDICAL EXAMINER: On the best of examination and/o						se(s) and manner as stated.
TO BE C	29b. SIGNATURE AND TITLE OF CERTIFIER			DISH	87	29d. DATE SIGN	NED/Month, Opr. (Car)
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT	EM 27) (Type, Print)	-	DX,	BNUT	IMD.	21233
	31. DAS ELE TOO 9 1994 Jale William William S SIGNATURE						

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Southern March Lagrange

94

3. TIME OF DEATH

10d. INSIDE CITY LIMITS? 1 TES 2 NO

14. RACE — American Indien, Black, White, etc. Specify: White

e. BIRTHPLACE (State or Foreign

12:05 Am

Approximate Interval Between Onset and Death

andenom

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH?

1 NES 2 NO

REG. NO.

2. DATE OF DEATH MONTH DAY

	1 1	4. SOCIAL SECURITY NUMBER	5. SEX	8. AGE (In yr	s. last birthday)	IF UNDER 1 Y	EAR	IF UNDER 24 HRS.	7. DATE C	F BIRTH	1	BIRTHPL	ACE (State or I
		213 52 0467	1 DM 2 DF	41	YRS.		AYS	HOURS MIN.	Apri	Day Mant	1953	Coperay	yland
phonid		9a, FACILITY NAME (If not institution, give a	treet and number)			9b. CITY, TO	WN O	R LOCATION OF			9c. COUNT		
9	2	Maryland Ger	neral Hos	oital			Bal	ltimore				-	
1, 2,	5	RESIDENCE OF DECEDENT									L		
nt. Pages	DIRECTOR	Maryland 10b. COUNT	altimore		10c. CIT	Y, TOWN OR L	SSE	ON CON					d. INSIDE CIT LIMITS?
020 physician. burial-transit permit. Pages	FUNERAL	100. STREET AND NUMBER 32 Stemmers	Run Rd.				101.	ZIP CODE 2122	1		10g. CITIZE	US	T COUNTRY?
215-0020 attending physician. se as the burlal-trar	BY FUN	11, MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA	YES 2	NO	If ye	s, spe	ENDENT OF HISP city Cuban, Mexi 2 NO Spe	ANIC ORIGIN? cen, Puerto Ri	(Specify Yealcan, atc.)	or No— 1	4. RACE -	American Inc.
1215- r attendi		15. DECEDENT'S EDU (Specify only highest grade		184	DECEDENT'S	USUAL OCCU	PATIO	N d of washing	16b.	KIND OF BUS	INESS/INDU	STRY	
E 8 2	IPLET	Elementary/Secondary (0-12)	College (1-4 or 5+)		life. Do NOT u	ounsel		i or working		Bo	y Scou	it Ca	mp
YLA by the be det	E COMPL	17. FATHER'S NAME (First, Middle, Lest) Basil	Spedalere					18. MOTHER'S I	_	iddle, Maiden	Surname)		
be retained ge 5 should e notified	TO B	19a. INFORMANT'S NAME (Type/Print) Willard J. Emerso	n		196. MAILING	ADDRESS (SI	treet an	ve. Ba	Route Number				
6 may ctor, pa		20e. METHOD OF DISPOSITION 1	oval from State	20b. PL/ cematan	CEAND DATE	of Disposition	N (Nan	ne of	12/1		CATION — CH		State
LTIM(sath, Page uneral direx		21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE			22 NAI	AE ANI	D APDRESS OF Zinski	FACILITY	7 77	Dalei	morre	
A S S S	Ш	* Alma &	July	7		144	07	Easterr	Ave.	Balt	imore	, MD	21221
in by remo		23. PAPT I. Enter the diseases, or ahock, or heart failure.	complications that List only one caus	caused the	e death. Do i	no1 enter the	mod	le of dying, se	ich aa cardi	ac or reapl	ratory arrea	it,	Approxim
F 9 F		IMMEDIATE CAUSE (Final disease or condition		TER	MIA	101		AIDS					Carle
ted with completely ial, cremati		reaulting in death)	aDUE TO (C		NSEQUENCE O		_/	دراار	-				una
68760 pecuted with and complet burial, cren	Z	Sequentially list conditions,	b										
DX be es cian sior to	CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	DUE TO (C	OR AS A CO	NSEOUENCE O	F):							
. B ifficati physine p	FIC	CAUSE (Disease or injury that initiated avents	c. DUE TO (C	OR AS A CO	NSEQUENCE O	F):		_					
O = 5 - 0	ERT	reaulting in death) LAST	d										
the deaty the att of Menta		PART ii. Other aignificant condition								24a. WAS AN			RE AUTOPSY
OH CHART AND THE AND T	DICAL	100M,	anem	in,	Sei:	me	d	Leious	en	PERFOR		CC	AILABLE PRIOR MPLETION DF DEATH?
RECC requires seen signal. of Health	Z									/	^\		YES 2
law law bept.	AN:	DID TOBACCO USE (25. WAS CASE REFERRED TO MEDICAL	CONTRIBUTE	TO CA	USE OF			S N					
T the ste	Sic.	EXAMINER?	HOSPITAL:	PD10 4 - 41		OTHER:		ACE OF DEATH (
T CIA	PHYSICI	27. MANNER OF DEATH	1 Nnpatient 2 2		28b. TIN		_	5 Residenc	_	(Specify)	NJURY OCCU	RED	
N OI OI OI OI OI OI OI OI OI OI OI OI OI	ВУ Р	Natural 5 Pending Investigation	(Month, Day	(Year)	IN	URY	WOR	RK? ES 2 NO					
·O-3 < 4	TED B	2 Accident 3 Suicide 6 Could not be determined	26a. PLACE OF building, e	INJURY — Atc. (Specify)	At home, farm,	atree1, factory,	offica		261. LOCA C/ly o	TION (Street a r Town, State)	and Number or	Rural Rout	e Number,
OR ATTEN OR ATTEN Hours after Hom 28 to	ш	29a. CERTIFIER 1 CERTIFYING PHYSI	CIAN: To the best of n	v knowlado	e, death occurr	ed at the time	date	and place, and d	ue to the cour	ve(a) and man	ner se stated		
	COMPL		R: On the beels of axe										nd manner as
TO THE HOSP TO THE FUNE De filed within	BE C	29b. SIGNATURE AND TITLE OF CERTIFIE	Regar	. /		0	T	29c. LICENSE N	UMBER		29d. DATE 1	SIGNED (M	onth, Day, Year
D D S WI	0 B		secre	ca C	u, m	.D.		892	26		1 /-	11/1	194
	-	30. NAME AND ADDRESS OF PERSON WH	CER / P	OF DEATH	(ITEM 27) (Type	Print)		R.	ORB	12	011	1	^
		11117 -1100	2010019	10 1	101/	10116			UNCO	cot	4,0	4.1	1

32. REGISTRAR'S SIGNATURE

This Devolear Randall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

SPEDALERE

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

31. DATE FILED (Month, Day, Year)

DEC1 9 1994

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with completely filled in by the funeral director, page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPARTI	MENT OF H	HEALTH AND		YGIENE REG. NO.		
	1. DECEDENT'S NAME (First, Middle, Last)						DEATH		3. TIME OF DEATH
	Maggie Smith					12-14	-94 DAY	Y	4:00 A M
	4. SOCIAL SECURITY NUMBER			F UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF (Month, D		8.	BIRTHPLACE (State or Foreign
	212-32-4077	1 🗆 M 2 🔀 🗏	87 YRS.	ONTHS DAYS	HOURS MIN.	l		1	Country) Maryland
	9e. FACILITY NAME (If not institution, give a	,			OR LOCATION OF DI	ATH -			OF DEATH
OR	Hopkins Bayvi	ew Center		Baltin	more Ci	ty			
2	RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY	v	I too CITY I	TOWN OR LOCA	7101				
DIRECTOR		imore	100. 0111,	IOWN OH LOCA	HON				10d. INSIDE CITY LIMITS?
	10e, STREET AND NUMBER	IMOLC		140	f. ZIP CODE				1 YES 2 NO
FUNERAL	118 Walnut Ave			10	21222		10	g. CITIZEN US	OF WHAT COUNTRY?
N N	11. MARITAL STATUS	12. WAS DECEDENT EVER I	NIIS ADMED	12 WM C DEC	ENOENT OF HISPAN	uc oncure «			
	1 Never Married 2 Merried	FORCES? 1 YES	2 WNO	If yes, sp	ecify Cuben, Mexica	n, Puerto Rica	n, etc.)	14.	RACE — American Indian, Black, White, etc.
BY	3 Widowed 4 Divorced	II 123, GIVE HAR OR D	ATES	1 L TES	2 NO Specifi	<i>(</i> :			Specify: Black
COMPLETED	15. DECEDENT'S EDUI (Specify only highest grade	CATION	18e. DECEDENT'S US (Give kind of work	UAL OCCUPATION	ON	16b. KII	ID OF BUSINE	SS/INOUST	TRY
91	Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use n	etired.)					
M I	12	2	Stenog:	rapher		S	teel		
8	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA				
BE (William Henry	Smith			Eliza	oeth :	Duniv	al	
2	19e. INFORMANT'S NAME (Type/Print)				and Number or Rural I				
-	Ruth S. Law		3302	Spring	dale A	ze. B	alto.	Md.	21206
	20e, METHOD OF DISPOSITION 1 Buriel 2 Cremetion 3 Rem	oval from State	PLACEAND DATE OF	DISPOSITION (Na		OATE			or Town, State
	4 Donation 5 Other (Specify)		Arbutus I				Balte		ld.
- 1	21. SIGNATURE OF FUNERAL SERVICE LIC	ENSEE -	0	DOUG T	O AODRESS OF FA	uum neral	Serv	ice	
_	(aulton	C. hldu	day		McCullo			100	
	23. PART I. Enter the diseases, or o	complications that cause	the deeth. Do not	enter the mo	de of dying, auci	n aa cardiac	or respirato	ry arrest	, Approximate
	iMMEDIATE CAUSE (Finel	Liet only one ceuse on e	ech line.						Interval Between Onset and Death
		Pancreatic	Cancer						10-11-15-1-11-1-1
	rounting in country		CONSEQUENCE OF):						
z I	Seguentially list conditions	b							
E	Sequentially list conditione, If any, leading to immediate	OUE TO (OR AS A	CONSEQUENCE OF):						
2	CAUSE (Disease or Injury	с							
	that initiated events resulting in deeth) LAST	DUE TO (OR AS A	CONSEQUENCE OF):						
CERTIFICATION		d							
AL	PART II. Other algnificent condition	e contributing to deeth b	out not reaulting in t	he underlying	ceuae given in	Pert i. 24	. WAS AN AUTO	OPSY	24b. WERE AUTOPSY FINDINGS
							PERFORMED		AVAILABLE PRIOR TO COMPLETION OF CAUSE
밀						''	YES 2 X	10	OF DEATH?
PHYSICIAN: MEDIC	DID TOBACCO USE CONTE	RIBUTE TO CAUSE C	F DEATH YES	Пиог	UNCERTAIN				1 1ES 225 HO
ğ	25. WAS CASE REFERRED TO MEDICAL		26. PLACE OF DEATH		OTTOLINA				
S	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 X Inpatient 2 ☐ ER/Outp		THER:	e 5 🗆 Reeldence	8 C Other /Sr	enciful		
⋛∥	27. MANNER OF DEATH	26e. DATE OF INJURY	28b. TIME O	F 28c. INJ	URY AT		BE HOW INJUF	Y OCCURE	ED
B ₽	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY		RK? /ES 2 NO				
	2 Outstday	28s. PLACE OF INJURY building, etc. (Spec	— At home, term, stree	et, fectory, office		28t. LOCATIO	N (Street end N	lumber or F	Rural Route Number,
ш	3 Suicide 8 Could not be		2019)			City or ic	wn, State)		
	4 Homicide determined								
LET	4 Homicide datermined		ledge, death occurred a	t the time, date	end piece, and due	to the causele) end menner	no stated	
OMPLET	4 Homicide datarmined 29a. CERTIFIER (Check only	CIAN: To the best of my know							suse(e) and manner se stated.
COMPLETED	4 Homicide datarmined 29a. CERTIFIER (Check only	CIAN: To the best of my know			eath occured at the	time, date end	place, end du	e to the ce	Z.III
띪	29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER	CIAN: To the best of my know. R: On the beste of exemination	n and/or investigation, i		eath occured at the 29c. LICENSE NUM	time, date end	place, end du	to the ce	GNED (Month, Day, Year)
띪	29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER	CIAN: To the best of my know.	n and/or investigation, i	n my opinion, d	eath occured at the	time, date end	place, end du	to the ce	Z.III
TO BE COMPLET	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINED 29b. SIGNATURE AND TITLE OF CERTIFIER PARIZEL	CIAN: To the best of my know. R: On the best of exemination R: On the best of exemination R: On the best of exemination	ATH (ITEM 27) (Type, Pri	n my opinion, d	eath occured at the 29c. LICENSE NUM 946 1	BER	place, end du	DATE SIGN	GNED (Month, Day, Year)
ᇤ	29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINED 29b. SIGNATURE AND TITLE OF CERTIFIER PARIZEL 30. NAME AND ADORESS OF PERSON WHO	CIAN: To the best of my know.	ATH (ITEM 27) (Type, Pri	n my opinion, d	eath occured at the 29c. LICENSE NUM	BER	place, end du	DATE SIGN	GNED (Month, Day, Year)

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within as hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1. 2. 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	FOR STATE REGISTRAR	STATE OF MARYLAND /	DEPARTI	MENT OF H	EALTH AND	MENTAL	HYGIENI REG. NO.	Ē		
	1. DECEDENT'S NAME (First, Middle, Last) LOVISE	SEKILIO				2. DATE MONTH	OF DEATH	-92	EAR 2.1	4.45 DM
	213097077	6. AGE (In yrs. les		F UNDER 1 YEAR ONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE (Month)	OF BIRTH		Country)	yland
H.	90. FACILITY NAME (If not institution, give stree Good Samaritan		9	Balti	TO THE	EATH		9c. COUNTY	OF DEATH	1
Ĕ.	RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY		100 CITY	TOWN OR LOCAT					Land	. INSIDE CITY
DIRECTOR	Maryland			imore	ION					LIMITS?
	10e. STREET AND NUMBER			101	. ZIP CODE	-		10g. CITIZEN	X	
FUNERAL	7023 E. Baltimo				1224			U.S		
BY	11. MARITAL STATUS 1	2. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2 XX IF YES, GIVE WAR OR DATES		If yee, sp	ENDENT OF HISPAI ecity Cuben, Mexice 2 NO Specif	n, Puerto R		or No— 14	Black, Wh	Americen Indien, offe, etc. Thite
COMPLETED	15. DECEDENT'S EDUCAT (Specify only highest grade col	mpleted) (G	CEDENT'S US ive kind of wor Do NOT use i	SUAL OCCUPATION done during more retired.)	ON st of working	16b.	KIND OF BUS	INESS/INDUS	TRY	
MP	5th		Homer	naker			Own	Home	3	
	17. FATHER'S NAME (First, Middle, Last) Angelo C	alo			18. MOTHER'S NA	ME (First, N				
BE	190. INFORMANT'S NAME (Type/Print)		b. MAILING A	DDRESS (Street e	Rose	Route Numb		gelo	ode)	
2	Michael Semili				ltimore					21224
	20e. METHOD OF DISPOSITION 1 Disposition 3 Ramova	20b. PLACE A	AND DATE OF	DISPOSITION (Na	me of	DATE		ATION — City		
	4 Operation 5 Other (Specify)	see Garde	ns of		h Cemet		Ba	altim	ore,	Marylan
	· Charles	Zaum		263	oh N. Z S. Conk	line	r St	R=1+	O N	11 Home
	23. PART I. Entar the diseases, or con abock, or heart fallure. Les	nollections that caused the de t only one cause on each line	ath. Do not	enter tha mo	de of dying, auc	h aa card	lac or reapir	atory arreat	,	Approximate Interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in death)	Possille DUE TO (OR AS A CONSEC	Sept DUENCE/OF:	ونع	3					Onset and Death
CERTIFICATION	Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated eventa resulting in death) LAST	Premote Due to (or as a consecutive to (or as a consecutive to the total	DUENCE OF):	orth,	plen	al	effer	3co	4.	
AL	PART II. Other algolficant conditions of	ontributing to death but not r	eaulting in	the underlying	cause given in	Part I.	24a, WAS AN A PERFORI 1 YES 2	MED?	AVAI	RE AUTOPSY FINDINGS ILABLE PRIOR TO IPLETION OF CAUSE DEATH?
PHYSICIAN: MEDIC	DID TOP ACCOUNTS	NITE TO CALLET OF DEAL						(,	1 🗆	YES 2 NO
AN	DID TOBACCO USE CONTRIE 25. WAS CASE REFERRED TO MEDICAL			(Check only one)	UNCERTAIL	ИПІ			<u></u>	
SIC	EXAMINER?	OSPITAL:		THER:	5 Reeldence	8 🗆 Other	(Specify)			
F	27. MANNER OF DEATH 1 Netural 5 Pending	28e. DATE OF INJURY (Month, Day, Year)	286. TIME (Y WO	RK?	28d. DE\$	CRIBE HOW IN	JURY OCCUR	REO	
B	2 Accident Investigation	28s. PLACE OF INJURY — At ho	me, farm, stre		ES 2 NO	281, LOCA	TION (Street or	nd Number or	Burni Bouto	Number
E I	3 Suicide 8 Could not be 4 Homicide determined	building, atc. (Specify)					r Town, State)	ia mamboi or i	io ar riodio	riumogi,
COMPLET		N: To the best of my knowledge, de On the beels of examination and/or I							euse(e) end	manner as stated.
TO BE C	296. SIGNATURE AND TITLE OF CERTIFIER_	Tompenai	eui		29c. LICENSE NUM D 30 (29d. DATE SI	GNED (Mon	11h, Day, Yeary K
	30. NAME AND ADDRESS OF PERSON WHO C	. TRIDU		int)	D300	1/	och	BAIL	ma. Ven	Blul.
	DEC1 9 1994	22. REGISTRAR'S SIGNATURE								

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DIVISION OF VITAL RECORDS, P.O. BOX

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Fours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

permit. Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR	STATE OF MARYLA	ND / DEPART			MENTAL HYGIEN				
1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH 3, TIME OF DEATH				
DLEATH	1A M. SPENCER			MONTH D	O 94	12:39hn m			
010 /0 0///			IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	Cov	THPLACE (State or Foreign		
		YRS.	ONTHS DAYS	HOURS MIN.	01/02	129,	FLORIDA		
9e. FACILITY NAME (If not institution, give street	1000000		9b. CITY, TOWN	OR LOCATION OF DE	ATH	9c. COUNTY OF	DEATH		
HARBOR MEDICAL C	ENTER		BALTO	•					
10e. STATE 10b. COUNTY		10c. CITY,	TOWN OR LOCA	TION			10d. INSIDE CITY		
MD		GI	EN BER	NIE			LIMITS?		
10e. STREET AND NUMBER	27.7		10	. ZIP CODE		10g. CITIZEN O	F WHAT COUNTRY?		
6463 COLONIAL KNO	- الم			21061		U.S.	Α.		
11. MARITAL STATUS 1 1 Never Married 2 Merried	2. WAS DECEDENT EVER IN U FORCES? 1 YES	U.S. ARMED 2 V NO	13. WAS DEC	ENDENT OF HISPAN	IC ORIGIN? (Specify Year, Puerto Rican, etc.)	or No — 14. R/	ACE — American Indian, sck, White, etc.		
3 Widowed 4 X Divorced	IF YES, GIVE WAR OR DAT	ES		2 NO Specify			ecity:		
15. DECEDENT'S EDUCAT	TION	16e, DECEDENT'S US	SUAL OCCUPATION	ON	165 KIND OF BU	IAFR			
(Specify only highest grade col	mpleted)	(Give kind of worlife. Do NOT use	rk done during mo retired.)	st of working	100.7000	3111L33/111D031A1			
12	Β.	OARD OF	ED. A.A	. CO.					
17. FATHER'S NAME (First, Middle, Lest)				18. MOTHER'S NAI	ME (First, Middle, Melden	Surname)			
ORLANDO SIMMONS				OPELIA	SIMMONS				
199. INFORMANT'S NAME (Type/Print)					loute Number, City or Tox				
MARGO SPENCER		6463 C	OLONIAL	KNOLL G	LEN BURNI	E MD 210	61		
20a METHOD OF DISPOSITION 1 Suriel 2 Gramation 3 Remova	if trom \$tale 20b.P	PLACE AND DATE OF	DISPOSITION (Na	ime of	DATE 20c. LC	CATION — City or	Town, State		
4 □ Donetion 5 □ Other (Specify) 21. BIONATUME OF FUNERAL SERVICE LICEN	AR	BUTUS ME		12/16/9		tus md.			
OF FORENCE GLEEN	X			BROS. F	UNERAL HON	ſΕ.Ρ.Δ			
(use	· Me	1	1300	EUTAW PL	ACE BALTO.	MD 212	17		
PART Finer the diseases, or con shock, or heart feliure. Lis	nplicetions that caused t	the death. Do not	t enter the mo	de of dying, such	es cerdisc or resp	ratory arrest,	Approximate		
IMMEDIATE CAUSE (Finel							interval Between Onset and Death		
e. Cardiogenic Shock. Due to (or as a consequence of):									
	DUE TO (OR AS A C	CONSEQUENCE OF):				1			
Sequentielly list conditions, b	Acute 1	wein	wall	Myoc	ardial o	huferch	us		
if sny, lesding to immediate ceuse. Enter UNDERLYING	DUE TO (OR AS A C	ONSEQUENCE OF):	LIEAR	- 60	30				
CAUSE (Disease or injury that initieted events	CONGES DUE TO (OR AS A C	ONSEQUENCE OF:	FICHR	1 PA	ALURC.				
resulting in death) LAST	,	,					Ĺ		
0.									
PART ii. Other significent conditions of	ontributing to deeth but	not resulting in	the underlying	g ceuse given in i	Part i. 24s. WAS AN PERFOI		4b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO		
					1 YES :	NO	COMPLETION OF CAUSE OF DEATH?		
							1 - YES 2 - NO		
DID TOBACCO USE CONTRIE				UNCERTAIN					
EXAMINER?	IOŞPITAL:		THER:						
1 YES 2 NO 14	Inpatient 2 ER/Outpet	lerit 3 DOA 4		e 5 🗆 Residence					
1 Netural 5 Pending	(Month, Day, Year)	INJUR	WO WO	RK?	28d. DESCRIBE HOW I	NJURY OCCURED			
2 Accident Investigation 3 Suicide 6 Could get be	28s. PLACE OF INJURY -	- At home, term, atra			26t. LOCATION (Street	and Number or Dun	of Doubs Mumber		
4 Homicide determined	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Town, State)	ind number of nure	r rioute number,		
29a. CERTIFIER (Check only) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, end due to the ceuse(e) and menner as stated.									
							n(a) and manner as stated		
2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER									
Control and the second	LOUSE S'	TAFF		29c. LICENSE NUM	BER	29d, DATE SIGNI	ED (Month, Day, Year)		
30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DEAT	H (ITEM 27) /Time Pi	rint)			12	(3) 17		
PRATIBHA	SHARMA	HAR		SPITAL	CENTE	e- BA	LTIMORE.		
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNAT	URE L M							

Memory antone

ours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 68760,

	D. R. D											9	L	3/4	66
, le	FOR # 9b F	ilm # G	718 12-19-1 STATE OF N	94 N.A Maryla	ND / DEPA	unera.	l home	e H ealt h	AND	MENTAL	HYGIE	NF			
	REGISTRAR				CERTI	FICAT	E OF	DEAT	ГН		REG. N				
	1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MANY MANY MANY MANY MANY MANY MANY MANY										3. TIME OF				
	JESSIE JEANETTE				SEIBEF	T				DEC". I		14	94	124	5 p
- 1	4. SOCIAL SECURITY NUM		5. SEX	(Max					OATE OF BIRTN (Month, Day, Year)		8. BIRTI Count	HPLACE (State	or Foreign		
	213-26-306	7	1 🗆 M 2 💢 F	67	YRS.	MONTHS	DAYO	HOURS	MIN.	Nov	17,	1927	Mar	yland	
	9e. FACILITY NAME (If not it					9b. CIT	Y, TOWN	OR LOCATIO	ON OF DE	EATH		9c. COI	9c. COUNTY OF DEATN		
O.	NORTH ARUNDEL HOSPITAL E.R. ANNAPOLIS Glen Burnie ANNE									ARUN	DEL				
DIRECTOR	RESIDENCE OF DE	10b. COUNT			100	(T) TOUR		T. 0.1							
E	172			1		ITY, TOWN		TION						10d. INSIDE	?
	Maryland 100. STREET AND NUMBER		e Arundel	<u> </u>	H	anove								1 TYES	
ERAL							10	f. ZIP CODE						WHAT COUNT	
Ä	7107 Fores	t Aven						210	_				.ted	State	5
FUN	11. MARITAL STATUS 1 Never Merried 2	Merried	12. WAS DECEDEN FORCES? 1	YES	U.S. ARMED	13.	If yes, sp	CENDENT O	F NISPAN	NIC ORIGIN	(Specify)	fee or No-	14. RAC Blac	E — Americes k, White, etc.	n Indien,
B	3 🔀 Widowed 4 🗌 Div		IF YES, GIVE W	AR OR DAT	TES			2 🔁 NO					Spec	Whit	
	15. DEC	CEDENT'S EDU	CATION	1	18e. DECEDENT	'S LISHAL (CCLIDATIO	ON		100	VIND OF B	HENESC IN	DUCTON	AATITI	LE
ETE	(Specify on Elementary/Secondary (ly highest grade	complated) College (1-4 or 5 +			work done	durina ma	ost of workin	g	100.	KIND OF B	USINESS/IN	DUSTRY		
	12	0-12)	College (1-4 or 5+	''	Hom	emake	r				Own	Home			
OMP	17. FATHER'S NAME (First, A	Aiddle, Last)						16. MOTE	VER'S NA	ME (First, N					
Ŭ	John		Michae	el					nna		radio, marac	our cornerroy			
0	190. INFORMANT'S NAME (Type/Print)			19b. MAILII	G ADDRES	S (Street e			Boute Numb	er Cify or Tr	own, State, Z	in Code)		_
2	Mrs. Patri	cia Hu	dson									rylar		076	
1	20g METNOD OF DISPOSIT	TION		20b. F		_				DATE	_				
ı	1 X Burlet 2 Cremation 3 Removal from State cametary crematory or other place)										-d				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ; 22. NAME AND ADDRESS OF FACILITY											ш				
	D 2/-	2	14/-	10		H	arry	H W	itzk	e Fur		Home			
	Harry	us /	·WILL	Re	/	_ 4	112	01d (Colu	mbia	Pike	Elli	cott	City	21043
- 1	23. PART I. Enter the d shock, or h	the deeth. Do ch line.	not ente	r the mo	de of dyl	ng, auc	h aa cerd	ec or res	piratory a	rreat,		oximate ral Betwee			
- II	IMMEDIATE CAUSE (Final disease or condition resulting in deeth) o. Multiple Injuries DUE TO (OR AS A CONSEQUENCE OF):										t and Deat				
	resulting in deeth)	\rightarrow	· Muy	106	- 1-	w	125								
ł			DUE TO	(Off AS A	CONSEQUENCE	DF):									
ON ON	Sequentielly liet conditions, DUE TO (OR AS A CONSEQUENCE OF):														
CAT	If any, leading to imme cause, Enter UNDERLY		DOE 10	(OH AS A C	CONSEQUENCE	OF):									
윤	CAUSE (Disease or Inju		c	OR AS A C	CONSEQUENCE	OE)									
RTIF	that initieted eventa resulting in deeth) LAS			(011110111		o.,.								İ	
E I			d											-	
DICAL	PART II. Other eignifice	ent condition	s contributing to	deeth but	t not resulting	in the u	nderiyin	g ceuse g	iven in	Pert I.		N AUTOPSY	24b	. WERE AUTO	
S I											1 -	2 NO		COMPLETION	
Ä										_	,			OF DEATH?	. □ NO
ž	DID TOBACCO U	ISE CONTI	RIBUTE TO CA	USE OF	DEATH Y	ES 🗍	NO Z	⊉ UNC	ERTAIN					7	
CIA	25. WAS CASE REFERRED T				B. PLACE DF DE			0110		• • •					
S	EXAMINER?		HOSPITAL: 1 ☐ Inpatient 2 X	Xn/Output	lent 3 🗆 DOA	OTHE 4 Nu		te 5 □ Re	eldence	6 🗆 Other	(Specify)				
표	27. MANNER OF DEATH		28e. DATE OF	INJURY	28b. T	ME OF	28c. INJ	URY AT	1	_		/ INJURY OC	CURED		_
BY F	1 Netural 5 Pending (Month, Day, Year) INJURY							YES 2	240	Oriver - and collis			3/2/		
	2 Accident 3 Suicide 8	Could not be	28e. PLACE OF	F INJURY -	At home, ferm	atreet, fec	tory, offic	•		281. LOCA	TION (Stree	t end Numbe		Route Number,	3100
	4 Nomicide	determined	ounoing,	etc. (Specify R1) (1	duna	2			- 1	RH	Town, Stat		Rid	GP 1	ed
E E	290. CERTIFIER 1 CERT	TIFYING PNYSI	CIAN: To the best of			1	time date	and alana	and due					1	0(.
Σ∥			R: On the beele of ex											and mane-	to a state of
8	29b. SIGNATURE AND THILE			1		,	7				prece,	_			
BE	THE STORM OF AND PALE	OF CERTIFIED	WIL	1				29c. LICE						(Month, Day,	
2	30. NAME AND ADDRESS O	E DEBSON MY	O COMPLETED ONLY	E OF PE	N ATEM 57 17	D-7-0		0.	C.M	1.E		D.	EC.	16,1	994
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BALTIMORE, MARYLAND 21215-0020

DESIGN OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPIN. ON ATTRIONAPHYSICIAN: The law requires that the death certificate be executed with.

The FUNETH RECORD when this certificate has been signed by the attending physician and completely if a in by the tuneral director, page 5 should be detached to the within 72 have the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation. or removal.

IMPORTANT. II them 28 is marked, or litem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	FOR 1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL HYGI				
	1. DECEOENT'S NAME (First, Middle, Last)	SNOC	d			2. DATE OF OEATI		ď4	3. TIME OF OEATH	
	4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE	5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24				10		HPLACE (State or Foreign	
	225-18-3967 9a. FACILITY NAME (If not institution, give a	1. M 2 F 8		MONTHS DAYS	HOURS MIN.	(Month, Day, Year) Country) 10-10-13 Unk			nk	
ا ۾	Levindale Nu				R LOCATION OF D					
6	Levindale Nursing Home Baltimore									
DIRECTOR	10e. STATE 10b. COUNT	Y	10c. CITY	TOWN OR LOCAT	ION				10d. INSIDE CITY	
	Md.			Baltim	ore				LIMITS?	
¥	10e. STREET AND NUMBER			101	ZIP CODE		10g. CIT	IZEN OF	WHAT COUNTRY?	
	2434 W. Belve	21	215	SA						
Never Married 2 Married FORCES? 1 YES 2 NO If yes, specify Cuban, Maxican, Puerto Rican, etc.) Hyes, specify Cuban, Maxican, Puerto Rican, etc.) Black, Whita, at 1 YES 2 NO Specify: Specify							14. RAC Blec	E — American Indian, k, White, atc.		
							White			
	15. DECEOENT'S EDU		16a. OECEDENT'S L	JSUAL OCCUPATION	ON .	18b. KIND OF	BUSINESS/IND	DUSTRY	willite	
COMPLETED	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give kind of wi life. Do NOT use	ork done durina mo	st of working	ios. Kino or	BOSINESS/III	JOSTAT		
릴	12	50,10ge (1-4 01 0 4)	Un	k.						
Š	17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	AME (First, Middle, Mai	den Sumeme)			
BE	Unk.				Uı	nk.				
2	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	AOORESS (Street a	nd Number or Rural	Route Number, City or	Town, State, Zip	Code)		
-	Lizzie Linton		861 P	ark Av	e. Bal	timore,	1D. 2	1201		
	20a. METHOO OF DISPOSITION 1 Burlal 2 Cremation 3 Ram	oval from State 20b	PLACE AND DATE OF	E DISPOSITION /No	me of	0 ATE 200	LOCATION	City on T	Ctata	
	4 Donation 5 Other (Specify)		Garriso	n Fore	st Vet	12-20+94	Owin	ngs	Mills,Md	
	21. SIGNATURE OF FUNERAL BERVICE LI	INDIA /	8	ATBé	rt P. T	Wylie F	H PA			
_	· KHUW	14/1		638	N.Gilmo	or St. 2	21217			
1	23. PART I. Enter the diseases, or ahock, or heart fallure	List only one cause on a	the death. Do no	ot enter the mo	de of dying, suc	ch es cerdisc or re	spiratory sr	rest,	Approximate Interval Between	
H	MANAGERIATE ANNOUGH AND									
	disease or condition resulting in death)	. Kest	1 RA10 (sh k	Rices	31			MIN.	
		. \ .	HRS							
S	Middleade or condition s. Respiratory Arrest but to (or as a consequence of): Aspiratory Previous Dut to (or as a consequence of): Dut to (or as a consequence of):									
F	If any, leading to immediate cause. Enter UNDERLYING	DUE TO JOH AS A	CONSEQUENCE OF	17						
CERTIFICATION	CAUSE (Disease or Injury that Initieted events	C. DUE TO (OR AS A	CONSEQUENCE OF	:	_					
=	resulting in deeth) LAST	d,								
5	PART ii. Other significant condition	as contributing to death h	ut not requiting is	the rededuler	anne shire le	Book I as some				
8	ANOXIC	ENCEPK	to 100 resulting I	524 U	csuse given in	PSR I. 24a. WAS	AN AUTOPSY FORMEO?	246	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
	Alorio	0700071				1 YES	2 NO		OF DEATH?	
Σ						-			1 TES 2 NO	
SICIAN: MEDIC	25. WAS CASE REFERRED TO MEDICAL			26 PI	ACE OF DEATH (C/	nock only one)				
25	EXAMINER?	HOSPITAL:		OTHER:		8 Other (Specify)				
PHY	27. MANNER OF DEATH	28a. DATE OF INJURY	28b. TIME	OF 28c. INJ	URY AT	28d. DESCRIBE HO	W INJURY OC	CURED		
	1 Natural 5 Pending	(Month, Day, Year)	INJU		RK? 'ES 2 NO	A A COLUMN))	
D BA	2 Accident Investigation 3 Suicide 8 Could not be	28s. PLACE OF INJURY building, atc. (Spec	- At home, farm, st	reel, factory, offic		281. LOCATION (Str	et and Number	or Rural I	Route Number,	
-	4 Homicide datarmined		,,			City or Town, Si	ate)			
COMPLETED	29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best of my know	ledga, dasth occurred	at the time, data	and place, and due	to the cause(s) and	menner as sta	ted.		
5		ER: On the basis of examination							s) and manner as stated.	
u II	296. SIGNATURE AND TITLE OF CERTIFIE	B(0.4.0-1.1			29c. LICENSE NU	MBER	29d. DAT	E SIGNED	(Month, Qay, Year)	
2	matter	who	en wil		D45	757	1 1	21	15/94	
-	30. NAME AND ADDRESS OF PERSON WH	O COMPLETEO CAUSE OF DE	ин (ітпы 27) (Туре, і	Print)						
			/							
	DEC1 9 1994	Austur Burd	MAN E							
	DECT 2 1004									

A lafter that the collection

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL ORECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Nem 28 is marked, or Nem 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.										
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH	EATH 3 TIME OF DEATN				
	Paul Joseph Vache	resse				December 9, 1994 2 P.					
«	4. SOCIAL SECURITY NUMBER		In yrs. last birthday)	7. DATE OF BIRTH (Month, Day, Year)	6. BIR	THPLACE (State or Foreign					
	233-05-4585		79 YRS.	MONTHS DAYS	HOURS MIN.	April 7,	1915 We	st Virginia			
	9a. FACILITY NAME (If not institution, give s	,			R LOCATION OF DI	EATN					
5	Laurel Regional +	lospital		Laurel			Prince George				
DIRECTOR	10a. STATE 10b. COUNT		10c. CITY	, TOWN OR LOCAT	ION		10d. INSIDE CITY LIMITS?				
₫		ward		Laurel				1 TYES 2 NO			
FUNERAL	10s. STREET AND NUMBER		101	ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?				
N.	8777 DOVES FLY WAY 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AR				20723			USA			
	1 Never Merried 2 Married	FORCES? 1 YES	2 NO	If yes, sp	city Cuban, Maxica	NIC ORIGIN? (Specify Ye in, Puarto Rican, etc.)	Puerto Ricen, etc.) Black, White, etc.				
ВУ	3)(X)(Widowed 4 Divorced			1 123	2 NO Specif	у.	ochy: White				
COMPLETED	t5. DECEDENT'S EDU (Specify only highest grade		16a. DECEDENT'S	ork done during mo		16b. KIND OF BU	SINESS/INDUSTRY				
J.	Elementary/Secondary (0-12)	College (1-4 or 5 +)	lite. Do NOT usa Pa	inter		D.	aint Com	ากสหป			
N O	17. FATHER'S NAME (First, Middle, Lest)	ν	100		18. MOTNER'S NA	ME (First, Middle, Maiden		party			
BE C	Edward Vacheresse	•				eth Bennet					
TO B	19e. INFORMANT'S NAME (Type/Print)					Route Number, City or Tow					
-	Patricia V. Hatto	in	877	7 Doves	tly Way,	, laurel,					
	20e. METHOD OF DISPOSITION 1 Burlel 2 (& Cremation 3 Removal from State 4 Donation 5 Other (Specify) Date D										
	4 Donation 5 Other (Specify)	ENSER /	Tunore	22. NAME AN	D ADDRESS OF FA	CILITY FROCK	Funoral	Home, Inc.			
	1 dal	Bulbak	21					el, MD 20707			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or reepiratory arrest,							Approximate				
	Interval Between IMMEDIATE CAUSE (Final disease or condition resulting in death) 3. Chessia Obstantiline pullmanay decimal										
N	The state of the s										
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING										
F	CAUSE (Disease or Injury that Initiated events	DUE TO (OR AS A	CONSEQUENCE OF):			<u>.</u>				
ERI	resulting in death) LAST	d									
AL C	PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY FINDINGS										
					000	PERFO		AVAILABLE PRIOR TO COMPLETION OF CAUSE			
MEDIC								OF DEATN?			
ä											
PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:		28. PL OTHER:	ACE OF DEATH (Ch	eck only one)					
H⊀S	1 YES 2 NO	t Inpatient 2 ER/Outp	atlant 3 DOA			6 Other (Specify)	IN ILIEN OCCURED				
	1 Natural 5 Pending	(Month, Day, Year)	INJ		RK?	28d. DEŞCRIBE HOW INJURY OCCURED					
ED BY	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarminad	26s. PLACE OF INJURY building, etc. (Spec	— At home, farm, a	treet, factory, offic		281. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
H	20a CERTIFIER										
COMPLETED	29s. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end placs, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.										
E C		29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)									
TO BI	giden fee	Menone	1		036	7/6	D /2/	9/94			
F	30. NAME AND ADDRESS OF PERSON WN		ATN (ITEM 27) (Type, 7 CHERR		1 -	46. 14. 14	2070	7			
	31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN		T LAN	- CAU	NEC, MA	~0 / 6) /			
	DEC1 9 1994	John Devolver &	erolati								

and the second of the second

31. DATE FILEO (Month

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -STATE REGISTRAR CERTIFICATE OF DEATH REG. NO DECEDENT'S NAME (First, Middle, Last, 2. DATE OF DEATH MONTH 3. TIME OF DEATH 5:00 A lans 12 5. SEX 8. BIRTHPLACE (State or Foreign Pountry) Royal Caroling 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH DAYS HOURS 1 M 2 F YRS. me permit. Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH DIRECTOR enter 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Battimore YES 2 NO FUNERAL 10e. STREET AND NUM 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? THE STATE LITE LAW TEQUITES THAT THE LEADING DEFICIENT CONTINUES After death. Page 6 may be retained by the hospital or attending physician. THE SPACE AS BEEN SIGNED by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or remnnal. 21216 a13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-H was asselfy Cuben, Mexican, Puerto Ricen, etc.) WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 11. MARITAL STATUS 14. RACE — American Indian Black, White, etc. If yes, specify Cuben, Mexican, Puerto Ri 2 Merried IF YES, GIVE WAR OR DATES ВҮ 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION secify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY College (1-4 or 5+) tomemalcer once. 17. FATHER'S NAME (First, Middle 18. MOTHER'S NAME /F notified at BE 19b. MAILING ADORESS (Street ar 2 21216 must be 20b. PLACE AND DATE OF DISCOSITION (Ne 20e METHOD OF DISPOSITION
1 Number 2 Cremetion 3 Res Donation 5 - Other (Specify) Injury, or other traumatic event, the medical examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE L 0 23. PART. Enter the diaeases, or complications that caused the death. Do not enter the mode of dying, such as Approximate shock, or haart failure. List only one causa on each lina. Intarvai Between IMMEDIATE CAUSE (Final Onset and Dasth disease or condition Myocande OR ATTENDING PAYSICIAN; The law requires that the death certificate be executed within resulting in death) DUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, OUE TO (OR A if any, laading to immediata cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE AF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not reaulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? PERFORMED? PMG shows any 1 TYES 2 BING 1 | YES 2 | 110 DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item EXAMINER? HOSPITAL OTHER s after death with the St 1 28 is marked, or It Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 28e. OATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural BY 1 YES 2 NO 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) COMPLETED DIRECTOR 4 Homicide II ilem hours 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end manner ee stated. ERAL in 72 h 2 MEDICAL EXAMINER: On the sele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(s) end manner es stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Juana J 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ONC Mo Der

RECORDS,	
OPVITAL	
DIVISION	

		FOR STATE REGISTRAR	STATE OF MARYL	AND / DEPAR CERTIF	TMENT OF	F HEALTH AND	MENTAL HYGIEI				
		1. DECEDENT'S NAME (First, Middle, Last) Adam Peter					2. DATE OF DEATH MONTH December	74 198	3. TIME OF DEATH 2:05 A		
P		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE ((In yrs. last birthday)	IF UNDER 1 YEA		7. DATE OF BIRTH		BIRTHPLACE (State or Foreign Cappy)		
, 2, 3 should	стоя	98. FACILITY NAME (If not institution, give Franklin Sq. RESIDENCE OF DECEDENT			_	OSSVILLE	EATN		sc. county of DEATN Baltimore		
permit. Pages 1,	DIRE	10m, STATE 10b, COUNT	altimore	10c. CIT	Y, TOWN OR LO			10d. 1 [
.FS	FUNERAL	807 Silver				101. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA			
21215-0020 al or attending physician. for use as the burial-transit	BY	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA	2 📉 NO	If yes	DECENDENT OF HISPA i, specify Cuben, Mexic YES 2 NO Specific	ne or No- 14.	RACE — American Indian, Black, White, atc. Specify: White			
MARYLAND 21 retained by the hospital or 5 should be detached for u notified at once.	COMPLETED	15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12)	JCATION e completed) College (1-4 or 5+)	18e. DECEDENT'S (Give kind of ville. Do NOT us Main	USUAL OCCUP work done during in retired.) itenanc	most of working		18b. KIND OF BUSINESS/INDUSTRY Steel Mill			
	BE COM	17. FATHER'S NAME (First, Middle, Last) Denjamin	Wardak		18. MOTHER'S NAME (First, Middle, Meiden Surneme) Camelia ?						
	10	196. MAILING ADDRESS (Street and Number of Rural Route Number, City by Fown, State, Zip Code) 807 Silver Ave. Baltimore, MD 21221									
BALTIMORE, er death. Page 6 may by the funeral director, page val.		20e. METNOD OF DISPOSITION 1 Deurles 2 Cremetion 3 Ren 4 Donation 5 Other (Specify) 21. SUMMATURE OF FUNERAL SERVICE LI	noval from State	PLACE AND DATE OF	Pait	h Cemeter	y 12/17/94		or Town, Stata		
BALTIMORE, is after death. Page 6 may be not by the funeral director, page removal.	_4	Janu 1	angleton		140	7 Eastern	Funeral Ho Ave. Bal	timore.	MD 21221		
68760, executed within 24 hours and completely filled in to o burial, cremation, or rei	NOI	23. ART I. Enter the diseases, or abock, or heert failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditione, if sny, leading to immediate	e. Myocardia DUE TO (OR AS A Atherosc DUE TO (OR AS A	mode of dying, suc	n es cardisc or resp	olifatory arrest,	Approximete interval Between Onset and Death 3 hours				
P.O. B th certificate tending phys il Hygiene p or other	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted evente resulting in deeth) LAST		Hypertension 10 Due to (or as a consequence of):							
CORD; lires that the signed by the leatth and M ws any Inju	MEDICAL (PART II. Other significent condition	ns contributing to death be	ut not resulting i	n the underi	ying ceuse given in	Part I. 24s. WAS AF PERFO 1 YES	RMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
AL RE	N: M	DID TOBACCO USE CONT	RIBUTE TO CAUSE O	F DEATH YE	S 🛭 NO	☐ UNCERTAI	N 🗆		1 YES 2 NO		
EM	PHYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO	HOSPITAL: 1 X Inpatient 2 ER/Outp	28. PLACE OF DEAT	OTHER:	nne)	8 Other (Specific)				
Marked, the cell	ву РНУ	27. MANNER OF DEATN 1 X Natural 5 Pending Investigation	28e. DATE OF INJURY (Month, Day, Year)	28b. TIMI	E OF 28c. URY 1	INJURY AT WORK? YES 2 NO	28d. DESCRIBE NOW	INJURY OCCURE	D		
DIVISION OR ATTENDAGE DIRECTOR Aber hours after death item 28 is man	ETED	3 Suicida 8 Could not be 4 Nomicide datarmined	28e. PLACE OF INJURY building, etc. (Spec	— At home, ferm, a	street, factory, o	office	281. LOCATION (Street City or Town, State		ural Route Number,		
3 20 =	COMPL		ICIAN: To the best of my knowle						use(e) end manner ee stated.		
TO THE HOSP TAIL TO THE FUNERAL De filed within 72 IMPORTANT: II	TO BE	296. SIGNATURE AND TITLE OF CERTIFIE R. Chit 30. NAME AND ADDRESS OF PERSON WE	kki.	ATN (ITEM 27) (June	Print	29c. LICENSE NUI		29d. DATE SIG	INED (Month, Day, Year)		
		Ritu Chita	kki. M.D. 90	000 Fran		quare Driv	re Baltim	ore, MD	21237		
		31. DATE FILED (MODIF), Day, Year) DECI 9 1984	Japa Davolson Re	relath							

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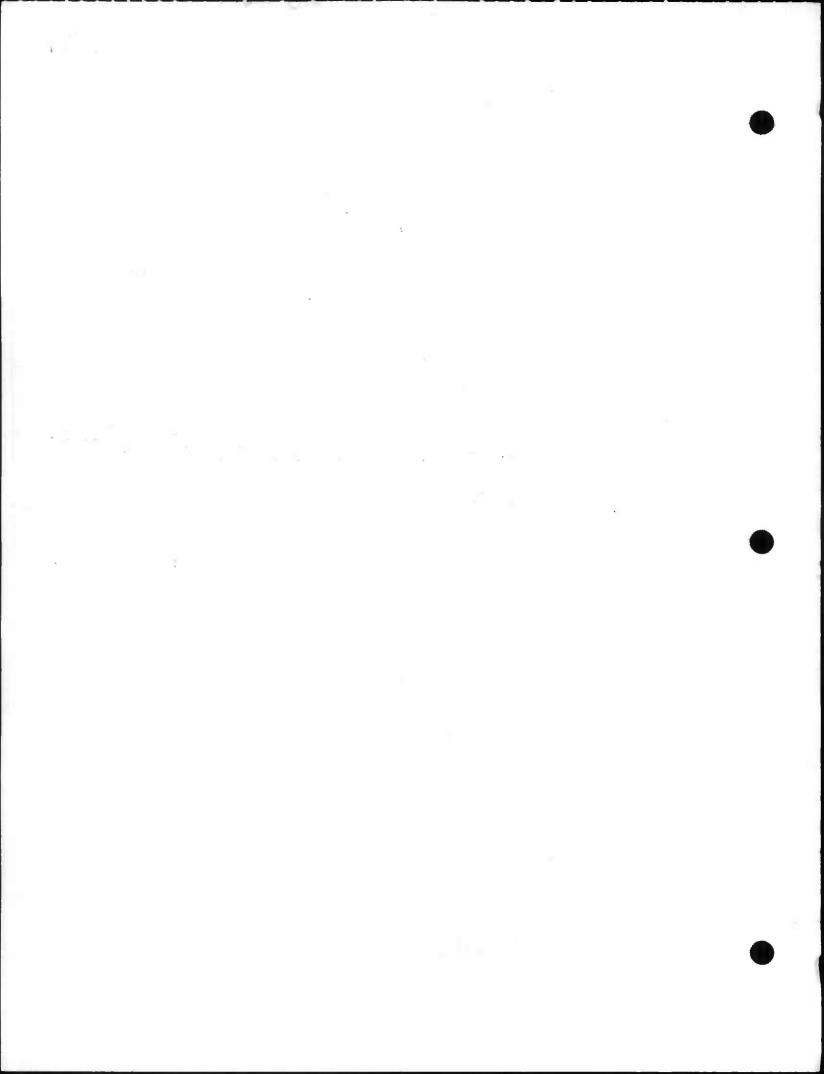
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		FOR 1 - STATE REGISTRAR		STATE OF I	MARYL			TMENT				MENTA	AL HYGIEN REG. NO.	E		
		1. DECEDENT'S NAME (First)	, Middle, Last)	Jes	sse	Woot	en					2. DATE OF OEATH DAY Y			EAR	TIME OF DEATN
pinous		4. SOCIAL SECURITY NUMBER 1243 - 03 - 39 (1) 99. FACILITY NAME (If not in	06_	5. SEX		(In yrs. lest b			DAYS	IF UNDER	MIN.	9 - :	E OF BIRTN ith, Day, Year) 22-15	6.	6. BIRTHPLACE (State or Foreign Country) NC	
1, 2, 3 sho	стоя	JOHNS HOPE	KINS H		L			BAL			ON OF DE	EATN 9c. COUNTY OF				N
permit. Pages	DIRE	MD	10b. COUNTY					r, town or TIMO]		ION					1	d. INSIDE CITY LIMITS? YES 2 NO
ist	NERAL	10e. STREET AND NUMBER 711 NMONT 11, MARITAL STATUS	CFORD					7		212	05	10g. CITIZEN OF V				
P	BY FUNI	1 Never Married 2 3		12. WAS DECEDEN FORCES? 1 IF YES, GIVE N	YES	2 - NO		if y	yes, spe	ctly Cube	or HISPAN In, Mexicer Specify	en, Puerto Rican, etc.) Bia				American Indian, hite, etc.
21 20 al or	PLETED	(Specify only Elementary/Secondary (0	EDENT'S EDU y highest grade	CATION completed) College (1-4 or 5	+)	(Give life, De	kind of w	PENT'S USUAL OCCUPATION ind of work done during most of working NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY				ım
INORE, MARTLA Page 6 may be retained by the I director, page 5 should be det ner must be notified at on	E COMPL	12 MAINTENANCE 17. FATHER'S NAME (First, Middle, Last) ROME WOOTEN								HER'S NAI	ME (First,	Middle, Maiden			11	
	TO B	190. INFORMANT'S NAME (7) EVELYN W(ype/Print)										nber, City or Town			5
	1000	20b. PLACE AND DATE OF DISPOSITION 1 Direction 3 Permoval from State 2 Donatton 5 Other (Specify ENTOMBMENT) 20b. PLACE AND DATE OF DISPOSITION (Name of complex), cremetory or other place) 20b. PLACE AND DATE OF DISPOSITION (Name of complex) 20b. PLACE AND DATE OF TOWN, State 20b. PLACE AND DATE OF TOWN, State 20b. PLACE AND DATE OF TOWN, State 20b. PLACE AND DATE OF TOWN, State 20b. PLACE AND DATE OF TOWN, State 20b. PLACE AND DATE OF TOWN, State 20b. PLACE AND DATE OF TOWN, State 20b. PLACE AND DATE OF TOWN, State 20b. PLACE AND DATE OF TOWN, State 20b. PLACE AND DATE OF DISPOSITION (Name of complex) 20b. PLACE AND DATE OF TOWN, State 20b. PLACE AND DATE OF TOWN, STATE OF TOW											State			
SALT r death. F e funeral al.		June	en Z	Rede	9			RE	DD	FUN	ERA	L S				MONROE ST
filled in to ion, or re-		23/PART I. Enter the di shock, or hi IMMEDIATE CAUSE (Fir disease or condition resulting in deeth)	eart fallure.	Liet only one cer	dee on e	ach line.									,	Approximate Intervei Between Onset and Death
executed n and com to burial, imatic ev	VTION	disease or condition resulting in deeth) a. ACMTE MYOCAR DIAC INFARCTION DUE TO (OR AS A CONSEQUENCE OF): B. CONCOMPARY ANTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF):														
ath certificat tending physical al Hygiene p	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST d.														
That the d and by the th and Mea	MEDICAL C	PART II. Other significe	AC	Ann		ut not ree		n the unde	erlying	ceuee	given in i	Pert i.	24a. WAS AN PERFOR 1 YES 2	MEO?	CO OF	RE AUTOPSY FINDINGS NILABLE PRIOR TO MPLETION OF CAUSE DEATH?
AL KEC he law required has been sign a Dept. of Heal m 23 shews	SICIAN: M	DID TOBACCO U 25. WAS CASE REFERRED TO	SE CONTI					S N (Check only		UNC	ERTAIN				1 (YES 2 NO
CIAN: The State or Item	YSIC	EXAMINER? 1 YES 2 NO 27. MANNER OF DEATN		HOSPITAL: 1 inpatient 2.2			DOA	OTHER:	_		eldence	_				
App. Cal.	BY BY	1 Naturel 5 1 Accident	Pending Investigation	(Month, D	lay, Year)		28b. TIME INJU	M		PRY AT RK?	NO		SCRIBE NOW IF			
OR ASSETTION.		4 Homicide	Could not be determined	building,	efc. (Spec	ify)						City	CATION (Street e or Town, Stete)		Hural Houte	Number,
HOSPITAL TUNERAL WITHIN 72 h	COMPL	(Check only t CERT	CAL EXAMINE	CIAN: To the best of R: On the beels of e						ath occur	ed at the t	lime, det		d due to the c		d manner ee stated.
THE THE IMPORT	TO BE	30. NAME AND ADDRESS OF	nth	COMPLETED CALL	SE OF DE	ATN //TEM 2	T) (Time	Defmel .		29c, LICE	30	2 7	2	P //	GNED (M	13, 1994
		31. DATE FILED (Month, Day,	ts"	5. N	1/4	en	y (1910°0, 1	W	A-5H	1/1	GT	on	1 140	LLAG	F G	13, 99 y
		DEC1 9 199	4 Jul	divole	Red	IL	_							CE	NE	7



3. TIME OF DEATH

12:05A

10d. INSIDE CITY

5.A

14. RACE — American Indian, Black, White, atc.

1 YES 2 NO

Black

21216

Approximate

WERE AUTOPSY FINDINGS

AVAILABLE PRIOR TO COMPLETION OF CAUSE

OF DEATH? 1 TES 2 TO

29d. DATE SIGNED (Marith, Day, Year,

12 12 94

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intervei Between

Onset and Death

Va

8. BIRTNPLACE (State or Foreign

Sc. COUNTY OF DEATH

10g. CITIZEN OF

29/10

Dureau

2. DATE OF DEATH

7. DATE OF BIRTH

12

TIMORE, MARYLAND 21215-0020

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

31. DATE FILED (MONTH, Pay, Year)
12 12 18 61 9 190

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6. AGE (In yrs. last birthday)

5. SEX

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4. SOCIAL SECURITY NUMBER

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VISION OF VITAL RECORDS, F.O. BOX 00700,	With
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,	ATTENDING PHYSICIAN: The law requires that the death certificate be executed a
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HOURS 400-38-476 1 M 2 - F DAY8 -3 9a. FACILITY NAME (If not institution, give stree 9b. CITY, TOWN OR LOCATION OF DEATH Secour 2000. DIRECTOR RESIDENCE OF DECEDENT 10a, STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MU Ba permit. FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE St 2/2/6 page 5 should be detached for use as the burial-transit the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-H was exactly Cuban, Mexican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS If yes, specify Cuban, Mexican, Puerto Ri
1 YES 2 NO Specify: 1 Never Married 2 Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) notified at unknown age 6 may be retained by BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Codel 2 2 20a. METHOD OF DISPOSITION
1 M Burial 2 Cremation 3 Re-20b. PLACE AND DATE OF DISPOSITION (Name of 20g-LOCATION -- City or Town, Stata DATE must director, 4 Donetlan 6 Dother (Specify) examiner 21 SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY funeral March Fift. West rome Trumpson JR 4 Wabash n by the removal. medical 23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in by shock, or heart failure. List only one cause on each line. 6 the attending physician and completely illed if Mental Hygiene prior to burial, cremation, or IMMEDIATE CAUSE (Final the disease or condition memary reaulting in death) Injury, or other traumatic event, BUE TO (OR AS A CONSEQUENCE OF CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART ii. Other aignificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? MEDICAL by t shows any been signed pt. of Health a 1 - YES 2 -0 PHYSICIAN: has be Dept. Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) certificate to the State HOSPITAL:
1 Vinpatient 2 ER/Outpatient 3 DOA OTHER: 1 TYES 2 NO 4 Nursing Home 5 Residence 6 Other (Specify) marked, or 27. MANNER OF DEATH 28b. TIME OF INJURY N M 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT NA 28d. DESCRIBE NOW INJURY OCCURED 1 Natural with N A A N 5 Pending 1 YES 2 NO BY death After Accident 281. LOCATION (Street and Number or Rural Route Number, City or Town (State) 3 Sulcide 28s. PLACE OF INJURY -- At home, farm, building, atc. (Specify) 60 DIRECTOR: / ED 4 Nomicide 28 N 72 hours OMPLET 29a. CERTIFIER (Check only one) 296. SIGNAPHRE AND TITLE OF CERTIFIER

S. Jahrmanahm 29c. LICENSE NUMBER ma 24983 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATHLITEM 27) (Type, Print) Baltimory Avenue

32. REGISTRAR'S SIGNATURE

A Julia Shudkor Ravialle

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR

IF UNDER 24 HRS.

DHMH-16 Rev 1/89

21230

THE REAL PROPERTY OF THE PROPERTY AND A STREET AND A STREET AS A S

3. TIME OF DEATH

10;50 A.

DHMH-18 Rev 1/89

8. BIRTHPLACE (State or Foreign

2. DATE OF DEATH DAY DECEMber 17, 1994

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

4. SOCIAL SECURITY NUMBER

모		216-10-1331	1 □ M 2 🔀 F	77	YRS.	MONTHS	DAYS	HOURS		ay 28,	917	Mary	land
pluods	-	9a. FACILITY NAME (If not institution, give							OF DEATH			TY OF DEATH	-
1, 2, 3	DIRECTOR	Meridan Frankli	n woods				Ross	ville	e		Bal	timore	≥
	1 8	10a. STATE 10b. COUNT	Υ		10c. CIT	Y, TOWN OR	LOCATIO	ON				10d	. INSIDE CITY
permit. Pages		Maryland			В	altim	ore	, Ci	ty			1 [XYES 2 NO
	RAL	10e. STREET AND NUMBER					10f. 2	ZIP COOE			10g. CITIZI	EN OF WHAT	
ian. transi	FUNER	3912 Wilke A	12. WAS DECEDENT	FIFTO IN LIG. LOS				2120				U.S.	
020 physician. burial-transit		1 Never Married 2 Married	FORCES? 1 [YES 2 WN	O NED	- 17	yes, spec	offy Cuban,	Maxican, Pu	RIGIN? (Specify Yearlo Rican, etc.)	or No — 1	Black, Wh	American Indian, ilta, atc.
215-0020 attending physician. se as the burial-trar	B	3 Widowed 4 Divorced	I TES, GIVE VA	IN ON ONIES		''	TES 2	≥ ⊠ мо	Specify:			Specify	ite
	日日	15. DECEDENT'S EDU (Specify only highest grade	CATION completed)	(G)	ve kind of v	USUAL OCC	CUPATION uring most	of working		16b. KIND OF BU	SINESS/INDU		
ortal or	LET	Elementary/Secondary (0-12)	College (1-4 or 5+)	are.	DO NOT US	e retirea.)			D	11 1.5		٠.	•
MARYLAND 2 retained by the hospital 5 should be detached to	once.	17. FATHER'S NAME (First, Middle, Last)		I ACC	ount	ant -				. Hopk i		spita	1
YLA by the	111		eering							a Hughe			
MAR retained 5 should	TO BE	19a. INFORMANT'S NAME (Type/Print)	ci iliq	196	MAILING	ADDRESS (Street and			Number, City or Tow		Code)	
be ret		Charles F. Albe	ert			ame a							
may or, pag	must be	20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Rem	noval Irom Stata	20b. PLACE A	ND DATE	OF DISPOSIT	ION (Name	ent		OATE 20c. LO	CATION — CI	Ity or Town, S	State
Pag i		4 Donation 5 Other (Specify)	пенове Л	Garde	ns of	Fai	th C	emete	ery 1	2/20/94	Balt	to. Mo	1
ath. P	Ē	and the second	7.			122. N/	eona	rd J.	OF FACILITY RUCK	, Inc.			
BALT after death. by the funera	Si ex	y mald (Jeks	Wh.		177	53	305	Harfo	ord Ro	1. 2121	4		
in t	medicai	23. PART I. Enter the diseases, of shock, or heart fallure.	complications that List only one caus	caused the dea e on aach lina.	ath. Do r	ot antar ti	he mode	a of dying	g, such as	cardiac or reap	ratory arres	at,	Approximata Intarval Batwee
4 量 5	the	IMMEDIATE CAUSE (Final disease or condition Presulting in death) Breat CA with Moti											
ted within 24 completely fille ial, cremation,	event,	reaulting in death) DUE TO (OR AS A CONSEQUENCE OF):											
S7 87		Sequentially list conditions a Hypohywardyw.											
A 64	traumatic	Sequentially list conditions, our to the AS A CONSEQUENCE OF):										——————————————————————————————————————	
BOX cate be e offysician a	ICA Ta	CAUSE (Disease or Injury											
Certifi ding p	ry, or other traumatic CERTIFICATION	that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST											
S, P. e death c he attend Mental Hy	CER of		d			_							
CORDS, res that the de signed by the a lealth and Meni	hows any injury, MEDICAL CI	PART II. Other algorificant condition	na contributing to d	laath but not re	aulting i	n tha unda	arlying	cause giv	an in Part	i. 24a. WAS AN PERFOR			E AUTOPSY FINDING
uires the	NEDICAL					_				1 YES 2	NO		IPLETION OF CAUSE DEATH?
HE SHAME	M M	DID TORACCO LISE CONT	DIDLITE TO CAL	ICE OF DEAT	ru vr	C 🗆 N		LINIOS		,		1 🗆	YES 2 NO
Z/	CIAN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	T CAU			H (Check on		UNCE	RTAIN [
5 5 S	10g	EXAMINER?	HOSPITAL:			OTHER:		5 Reald	lencs 8 🗆 4	Other (Specify)			
THE STATE OF THE S	PHY (0)	27. MANNER OF DEATH	28a. DATE OF III (Month, Day		28b. TIM		8c. INJUR	RY AT		DESCRIBE HOW I	NJURY OCCU	RED	
	mark BY I	1 Natural 5 Pending 2 Accident Investigation			,			S 2 N	10				
VISION ATTENDING ECTOR Anny 1 after death	= 0	3 Suicide 8 Could not be 4 Homicide delarmined	28a. PLACE OF building, st	INJURY — At hor ic. (Specify)	ne, Jarm, s	treet, lactor	y, offica		281.	LOCATION (Street a City or Town, State)	and Number or	r Rurel Route	Number,
DIVISION OR ATTENDING DIRECTOR Ahar Nours after death	Item 28 PLETE	And CENTIFIED									<u>. </u>		
2 P P P		(Check only	CIAN: To the best of m										
HOSPITAL FUNERAL within 72	S S	2 MEDICAL EXAMINE	100	mination and/or ir	iveatigatio	n, in my opii	nion, dea	th occured	at the time,	date and place, an	d due lo lhe	cause(a) and	manner as stated.
물 물 등	MPORTANT: If D BE COM	29b. SIGNATURE AND TITLE OF CERTIFIE	all	_	M	A	2	29c. LICENS	NUMBER /	1202	29d. DATE S	SIGNEO (Mon	th, Day, Year)
223	일	30. NAME AND ADDRESS OF PERSON WH	O COMPLETED CAUSE	OF OEATH (ITEM	27) (Type.	Print)		/	/ 7]	117	16	-1171	74-
10		Dr. Siani	11 //	30 Holib			212	222					
	İ	31. DATE FILEO (Month, Day, Year)	Ja REGISTRAR	SOGNATURE									
		שבנה ששמן	MI WILLIAM	- Control									

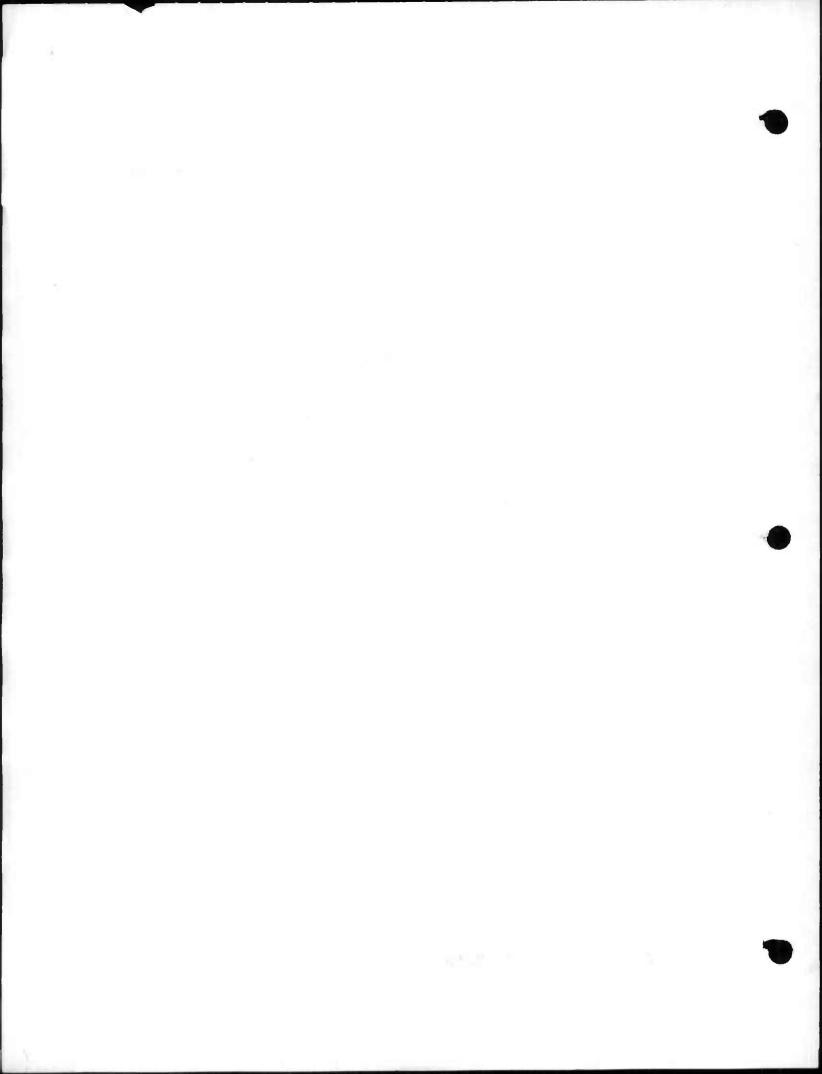
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH

Amelia Deering Albert

BALTIMORE, MARYLAND 21215-0020	INSCIANT. The law inquires that the death certificate be especiated within 24 you're after death. Page 6 may be retained by the hospital or attending physician	the certificate has been supred by the artending physician and competent filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Penes 1.2.3 sexuals	or removal.	
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HOSPITAL OF ATTEMBAS PHYSICIAN: The law requires that the death certificate be executed within 24	TO THE RUNERAL DISCUSSES AND this certificate has been signed by the attending physician and completely fills	he filed within A hours while death with the State Dept. of Health and Mental Hygene prior to burie, cremation, or removal.	

	1 - FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPART	MENT OF HEALTH AND CATE OF DEATH									
1	1. DECEDENT'S NAME (First, Middle, Last)	- 01 0 4			2. DATE OF DEATH		3. TIME OF DEATH						
	ANNE A	MPLE GAT	RTH		DEC.		9:00 A M						
	4. SOCIAL SECURITY NUMBER 200-36-9654	5. SEX 6. AGE			7. DATE OF BIRTH (Month Day, Year)	8. BIRT	HPLACE (State or Foreign						
1	9s. FACILITY NAME (If not institution, give s	treet and number)	. 0	9b. CITY, TOWN OR LOCATION OF (AC COUNTY OF	Maderphia						
5	ST. Agnes H	ospital		Baltimore		J. 300K11 07 L	ZAIN						
ا يُ	10s. STATE 10b. COUNTY	Y	10c. CITY,	TOWN OR LOCATION			10d. INSIDE CITY						
- 16	100. STREET AND NUMBER		1 YES 2 NO										
	303 Maiden Cl	na ce Lane	10g. CITIZEN OF WHAT COUNTRY?										
2		12. WAS DECEDENT EVER FORCES? 1 YES	IN U.S. ARMED	13. WAS DECENDENT OF HISPA	ANIC ORIGIN? (Specify Youn, Puerto Bican, etc.)	es or No- 14, RAC	E — American Indian, k, Whits, etc.						
5	3 Wildowed 4 Divorced	IF YES, GIVE WAR OR I	DATES										
3	15. DECEDENT'S EDUC	CATION	16s. DECEDENT'S U	SUAL OCCUPATION	16h KIND OF BI	I CINECO (INDI ICTOV	white						
ŀ			(Give kind of wo	rk done during most of working	IOO. KIND OF BI	DSINESS/INDUSTRY							
	8		rental	agent	Hox	100							
	17. FATHER'S NAME (First, Middle, Lest)			18. MOTHER'S N	AME, (First, Middle, Maide	n Sumame)							
ı II	Albert A.	LOLUGI		Weib	el Amo	lighton	NPV						
- 10	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING A	DDRESS (Street and Number or Rural	Route Number, City or To	wn, State, Zip Code)	110.4						
. 1	Dennis Sha	Kney	5524	1 Hightidge		Charles 1	MITOLOGY						
	29a METHOD OF DISPOSITION	corel from State				OCATION — City or To	wn, State						
I.	4 Donation 6 Other (Specify)		OUCOON Y	at K Cemeter	1 12/21	altimo	e.MD						
ı	21. SIGNATURE OF FUNERAL SERVICE LIC	()	0	22. NAME AND ADDRESS OF FA	ACLITY LO	M Tap	, , , , ,						
	1328 Julphur Spring Rand Baltimore MN 004												
7													
1	Interval Batween												
disease or condition Respiratory Failure													
1	rosoning in death)	DUE TO (OR AS	A CONSEQUENCE OF):			F-1	ess than I he						
	Secure Male to the second state of the	Metastatic Lung Cancer											
	Sequentienty list conditions.	0.	A CONSEQUENCE OF				3 200.1103						
	if any, leading to immediate	DUE TO (OR AS				C							
		c.											
	if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	c.	A CONSEQUENCE OF):										
	if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury	c.											
	if amy, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST	C. DUE TO (OR AS A	A CONSEQUENCE OF):	the underlying couse given in	Part i. 24e. WAS AF	N AUTOPSY 24b	WERE AUTOPSY FINDINGS						
	if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	C. DUE TO (OR AS A	A CONSEQUENCE OF):	the underlying ceuse given in	PERFO	RMED?	WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE						
	if amy, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST	C. DUE TO (OR AS A	A CONSEQUENCE OF):	the underlying couse given in	DEGEO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?						
	if amy, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST	C. DUE TO (OR AS A	A CONSEQUENCE OF):	the underlying couse given in	PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE						
	if amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other eignificant conditions 25. WAS CASE REFERRED TO MEDICAL	DUE TO (OR AS A	A CONSEQUENCE OF):	the underlying couse given in	PERFO	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?						
	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions	C. DUE TO (OR AS A	A CONSEQUENCE OF):	26. PLACE OF DEATH (Ch	PERFO 1 YES	RMED?	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?						
	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other eignificant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 No 27. MANNER OF DEATH	DUE TO (OR AS A d. e contributing to deeth b HOSPITAL: 1 M Inpatient 2 = ER/Outs	A CONSEQUENCE OF): but not resulting in patient 3 □ DOA 4 28b. TiME 0	26. PLACE OF DEATH (C): THER: Nursing Home 5 Residence F 26c. INJURY AT	PERFO 1 YES	RMED? 2 TM, NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?						
	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other eignificant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 M NO	DUE TO (OR AS A d. e contributing to deeth be HOSPITAL:	A CONSEQUENCE OF): but not resulting in	26. PLACE OF DEATH (C): OTHER: Nursing Home 5 Residence OF 25c. INJURY AT	PERFO 1 YES neck only one) 6 Other (Specify)	RMED? 2 TM, NO	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?						
	if amy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART ii. Other eignificant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be	DUE TO (OR AS A d. e contributing to deeth be HOSPITAL: Minpatient 2 ER/Outs	Dut not resulting in patient 3 DOA 4 26b. TIME C INJUR	26. PLACE OF DEATH (C/C) DTHER: Nursing Home 5 Reeldence PF 28C. INJURY AT WORK? M 1 YES 2 NO	PERFO 1 YES 1 YES 1 YES 26d. DESCRIBE HOW 26f. LOCATION (Street	INJURY OCCURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO						
	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1	DUE TO (OR AS A d. e contributing to deeth b HOSPITAL: 1 Management 2 ER/Outs (Month, Day, Year)	Dut not resulting in patient 3 DOA 4 26b. TIME C INJUR	26. PLACE OF DEATH (C/C) DTHER: Nursing Home 5 Reeldence PF 28C. INJURY AT WORK? M 1 YES 2 NO	PERFO 1 YES neck only one) 6 Other (Specify) 26d. DESCRIBE HOW	INJURY OCCURED	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO						
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	if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other eignificant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSIC	DUE TO (OR AS A d. B Contributing to deeth b HOSPITAL: 1 Minpatient 2 ER/Outs (Month, Day, Year) 26e. PLACE OF INJURY building, etc. (Spec	Dut not resulting in patient 3 DOA 4 26b. TIME (INJURY)	26. PLACE OF DEATH (Ch DTHER: Nursing Home 5 Residence OF 26c. INJURY AT WORK? 1 YES 2 NO	PERFO 1 YES: 1 YES: 1 YES: 1 Other (Specify) 26d. DESCRIBE HOW 26f. LOCATION (Street City or Town, State)	INJURY OCCURED and Number or Rural R	AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO						
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

The FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MINIOR MANUAL PROPERTY OF A BROWS AND Initure, or other traumatic event, the medical examiner must be notified at once.

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	1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO.										
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	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AMMED FORCES? 1 VES 2 NO If yes, specify Suben, Mexican, Puerto Ricen, etc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. RACE — American India Black, White, etc. 14. RACE — American India Black, White, etc.	ın,									
ED BY	15. DECEDENT'S EDUCATION 168. DECEDENT'S USUAL OCCUPATION 169. KIMD OF BUSINESS MUDICITY	-e									
COMPLETED	(Specify only highest grade completed) Elementary/Secondary (0:12) College (1-4 or 5+)										
TO BE	190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
8	Soly METHOD OF DISPOSITION 10 Burlet 2 Cremetton 3 Removal from State 200. PLACE AND DATE OF DISPOSITION (Name of parties) Completely crophatory or this place)										
100	Cemetion 3 Removal from State Cameton 5 Other (Specify) Other (Specify) Cameton 5 Other (Specify) Other (Speci										
CABILLE	1328 Sulphur Soring Road Balto Missi	327 TLC									
/	23. PABY I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac ar despiratory arrest, abock, or heart feliure. List only one cause on sech line. Approximation interval But in the cause of the ca	stween									
	IMMEDIATE CAUSE (Finel disease or condition resulting in death) e. Avoxic Encelholo bty 6.	Death									
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ERTIFI	that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): Hy Let to 1 and 1 an										
i O	PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? AMAILABLE PRIOR	NDINGS									
MEDICAL	1 U YES 2 NO COMPLETION OF COP DEATH?	AUSE									
	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO Z UNCERTAIN	10									
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ED BY	2 Accident Investigation 3 Suicide 8 Could not be determined 4 Homicide	_									
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COM	one) 2 MEDICAL EXAMINER: On the besis of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) and menner as at 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, West)	ated.									
1	Road Hobis 7. D.										

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

POY HABIB M, D JAINT AGNES

31. DATE FILEO (Month, Day, Veer)

DEC 2 0 1994

July Division Parish

NUF DZIZZ

AUE

900 CATON BALTING

NOSPITAL

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TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DEC2 0 1994

TIEMS: 23 PART I 27	, 28a-f, PER	MEO ETIN	M G_710	1/1/05	+ +			94	J	1410	
	STATE OF MARY					MENT	AL HYGIEN	E			
REGISTRAR					DEATH		REG. NO				
1. DECEDENT'S NAME (First, Middle, Last)						HOM		AY	3. TIME OF OEA		
MARK McClaine	B] BE (In vrs. lest b	ENNET			DE		7 19	94	1:07 PM		
		YRS. MONT	HS DAYS	IF UNDER 24 HRS. HOURS MIN.	(Mo	E OF BIRTH nth, Day, Year)		Counti	**		
219-70-1795 9e. FACILITY NAME (If not institution, give stree	M 2 G F	J1 .		CITY TOWN C	OR LOCATION OF		y 30 19		Mar	yland	
GOOD SAMARITAN I		BALTIMORE CITY					90, 000	MIT OF U	EAIN		
RESIDENCE OF DECEDENT					r.T.X						
10e. STATE 10b. COUNTY		10c. CITY, TOWN OR LOCATION Parkville									
Maryland Baltim		Park							1 YES 2 NO		
22 1 1 1 1 1 1 2 1 2 1 2 1 1 1 1 1 1 1				101	ZIP CODE	1		10g. CIT		WHAT COUNTRY?	
1727 Pin Oak Rd.	2. WAS DECEDENT EVER	R IN U.S. ARME	n	13 WAS DEC	21234 ENDENT OF HISP		IN2 /Cocalhy Van	or No.		E — American Indian,	
1 Never Merried 2 Merried	FORCES? 1 YE	8 2 XNO		If yes, spe	2 NO Spec	cen, Puerto	Rican, atc.)	0 NO-	Blaci	c, White, etc.	
3 Widowed 4 Divorced					· Kino obse	,ny.			Speci	White	
15. DECEDENT'S EDUCAT (Specify only highest grade co	'ION mpleted)	18a. OECE (G/ve	DENT'S USUA kind of work do NOT use retire	L OCCUPATIO	ON st of working	16	66. KIND OF BU	SINESS/IN	DUSTRY		
Elementary/Secondary (0-12)	College (1-4 or 5+)							°			
17. FATHER'S NAME (First, Middle, Last)	+1	Se	ervice	man				. & T.	·		
George B. Bennett					18. MOTHER'S N		, Middle, Maiden	-	ars		
190. INFORMANT'S NAME (Type/Print)	-	19b. N	AAILING ADDE	ESS (Street e	nd Number or Rura		mher City or Tow				
Billie Haddaway					Dr. Lev						
20e. METHOD OF DISPOSITION		Ob. PLACE AND	DATE OF DIS	POSITION (Na				_	City or To	wn, State	
1 Burlel 2x Cremetion 3 Remove 4 Donetion 5 Other (Specify)		emetery, creme Hillton	tory or other pla O Serv	ice Co	orp.Dece	ember	20 19	94	Tows	on Md.	
21. SIONATURE OF FUNERAL SERVICE LICEN					D ADDRESS OF F						
1 Kx11. #	\sim			Puck	Towern	Fune	ral Ho	me 1	150 V	ork Rd 2120	
23. PART I. Enter the diseases, or con	nolications that cous	ad the death	h. Do not er	tar tha mo	de of dying, su	ch as ca	rdiac or respi	ratory ar	rest,	Approximate	
shock, or heart failure. Lis	t Only Dna ceuse on	aech lina.								Interval Between Onset and Death	
disease or condition resulting in daeth)	NARCOTIC AN	D COCAIN	NE INTO	CICATIO	TION						
		DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, b.											
if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS	S A CONSEQUE	ENCE OF):								
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	ontributing to death	but not rase	uiting in the	underlylng	ı ceuse givan lı	n Part I.	24a. WAS AN PERFOR		24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO	
d	Ontributing to death	but not rase	uiting in the	underlying	j ceuse givan li	n Part i.	PERFOR		24b.		
PART II. Other significant conditions of							PERFOR	MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE	
d		OF DEATH	YES [] NO 🗆	uncerta		PERFOR	MED?	24b.	AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
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ED CAUSE OF DEATH (ITEM 27) (Type, Print)

DHMH-18 Rev 1/89

111 Penn Street, Baltimore, Maryland 21201

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DIVISION OF VITAL RECORDS, P.O. BOX 68/but DALIMONS. In the hospital or attending physician.

TO ENTIRONS PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after this certificate has been sixtle by the attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after the certificate has burial-transit permit. Pages 1, 2, 3 should hours after the state beat with the State Device. It is marked, or litem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO RE COMPLETED BY FUNERAL DIRECTOR

FOR

	1 - STATE REGISTRAR	STATE OF MARYL		MENT OF H		MENTAL	REG. NO.	E			
10000	1. DECEDENT'S NAME (First, Middle, Leat)	1. BELT				2. DATE O		194	3. TIME OF DEATH		
	4. SOCIAL SECURITY NUMBER 166-01-3618	5. SEX 6. AGE (IF UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE O (Mogth,	F BIRTH Day, Year)		MRTHPLACE (State or Foreign country)		
OR	90. FACILITY NAME (If not institution, give	90. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEA BALTI									
DIRECTOR	RESIDENCE OF DECEDENT	7	10c. CITY,	DOWN OR LOCAT	ION			U. C	10d. INSIDE CITY		
	MARYLAND BA	MIMORE	co. 1	ARKVI	ILLE				1 YES 2 AO		
FUNERAL	8606 DAVID) AVE		101.	2123	4		10g. CITIZEN	OF WHAT COUNTRY?		
	11. MARITAL STATUS 1 Never Merried 2 Merried	d 2 Merried FORCES? 1 YES 2 140 If yes, specify Cubarr, Mexican, Puerto Rican, atc.)									
D BY	3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify:										
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-4 or 5 +) College (1-5 or 5 +) College (1-5 or 5 or 5 or 5 or 5 or 5 or 5 or 5 or										
OMP	B - HOMENAKER OWN HOMES 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Melden Surname)										
BE C	NA THAN	KOPPENH	AVER		IDA	KA	THE	RINE	LONG		
2	196. INFORMANT'S NAME (Type/Print) MILDRED (4)	BAXTER	196. MAILING A	DDRESS (Street of	VID A	Houte Number	PAR	KVIVL	E, mD		
	20a. METHOD OF DISPOSITION 1		PLACE AND DATE OF etery, crematory or other	DISPOSITION (Nat	ne of Osol	OATE	20c. LOC	CATION — City o	or Town, State		
	21. SIGNATURE OF FUNERAL SERVICE LI	CENSES	1 1C. TE	22. NAME AN	D ADDRESS OF S	AGUITY A	20	of M	DNOR1153		
	Hypey	J. Jan 1	100677	380	50 H	4290	RD	RD.	PARKVILLE		
		List only one cause on e	I the death. Do no ech line.	t enter the mod	de of dyling, suc	ch se cerdi	ac or respir	ratory arrest,	Approximate interval Between Onset and Death		
	iMMEDIATE CAUSE (Final disease or condition resulting in death)	· Bo	sost (Jone.	21				7 Vans		
z	DUE TO (OR AS A CONSEQUENCE OF):										
ATIO	Sequentisity list conditions, if any, leading to immediate cause. Enter UNDERLYING										
CERTIFICATION	CAUSE (Discess or injury that initiated events resulting in death) LAST	C. DUE TO (OR AS A	CONSEQUENCE OF):								
		d									
CAL	PART II. Other significant condition	ns contributing to death be	ut not resulting in	the underlying	cause given in		PERFORI	MED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE		
PHYSICIAN: MED					,		1 U YES 2	L NO	OF DEATH? 1 YES 2 NO		
IAN:	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL		F DEATH YES		UNCERTAI	Ν□					
YSIC	EXAMINER? 1 YES 2 NO	HOSPITAL: 1 Inpatient 2 ER/Outp		OTHER:	5 Reeldenca	6 Other	(Specify)				
	27. MANNER OF DEATH 1 Natural 5 Pending	28e. OATE OF INJURY (Month, Day, Year)	28b. TIME (RK?	28d. OESC	RIBE HOW IN	JURY OCCURE	D		
ED BY	2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide datermined	28e. PLACE OF INJURY building, etc. (Speci	— At home, farm, stri			28f. LOCAT City or	TION (Street et Town, State)	nd Number or Ru	iral Route Number,		
PLET	29e. CERTIFIER (Check only) CERTIFYING PHYS	ICIAN: To the best of my knowl	edge, death occurred	at the time, date	end place, end du	e to the cause	e(s) end men	ner ee stated.			
One) 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end menner ee											
BE	296. SIGNATURE AND TITLE OF CERTIFIE	R E) No			29c. LICENSE NU	MBER		29d. DATE SIGN	NED (Month, Day, Year)		
2	Lat. MAME AND ADDRESS OF PERSON WI	IO COMPLETED CAUSE OF DE	ATH (ITEM 27) (Type, P.	rint)	030/6	4		12,	11/177		
	TAIL (PANO)	6569 No	CARUS	, Balt	- NO	212	204				
	31. OTEC 200 1994 Ju	A MERITAN PRO	arek:	,	/						

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DIVISION OF VITAL RECORDS, P.O. BO

FINAL PHYSICIAN: The law requires that the death certificate be executed within a found after death. Page 6 may be retained by the hospital or attending physician.	After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should	with the State Dept. of Health and Mental Hygiene prior to burfal, cremation, or removal.	i marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The	TO THE FUNERAL DHECTOR After this certificate ha	be liked within 72 hours uffer death with the State D	IMPORTANT. 77 28 is marked, or item

D BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE

TO BE COMPLETED BY FUNERAL DIRECTOR

							54		1-110
FOR 1 - STATE REGISTRAR	STATE OF MARY		RTMENT OF H) MENTA	L HYGIEN	_		
1. DECEDENT'S NAME (First, Middle, Last)		OLITTI	TOATE OF	DEAIII		E OF DEATH			3. TIME OF DEATH
Margaret A.	Binco				De	C.19	1994	YEAR	м
4, SOCIAL SECURITY NUMBER 5.	SEX 8. AGE	(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HR	7 DATE	OF BIRTH		8. BIRT	HPLACE (State or Foreign
220-03-3718	□ M 2 🔀 F	73 YRS.	MONTHS DAYS	HOURS MIN	∙ þďť	". 1°, "19	21	Mar	yland
9a. FACILITY NAME (If not institution, give street	t and number)		9b. CITY, TOWN O	R LOCATION OF	DEATH		9c. COU	INTY OF I	
408 Maryland	l Ave.]	Essex				Ba1	timore
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CIT	Y. TOWH OR LOCAL	ION					10d, INSIDE CITY
Md. Ba	altimore		FC	sex					LIMITS?
10e. STREET AND NUMBER	ittimore			. ZIP CODE			10a, CIT	IZEN OF	WHAT COUNTRY?
408 Maryland	Ave.			212	21			USA	
11. MARITAL STATUS 12	2. WAS DECEDENT EVER			ENDENT OF HIS			or No-	14. RAC	E — American Indian, k, White, atc.
1 Never Married 2 Married 3 X Widowed 4 Divorced	FORCES? 1 YES			ecify Cuben, Me: 2X NO Sp		Rican, atc.)		Spec	offy:
			1						White
15. DECEDENT'S EDUCAT (Specify only highest grade con	mpleted)		WORK done during mo		16	b. KIND OF BU	SINESS/INI	DUSTRY	
Elementery/Secondary (0-12)	College (1-4 or 5+)		oneRepa	airSer	vice		C&P		
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S	NAME (First.	Middle, Maiden	Sumame)		
Henry Conrad	Kroll			Marg	aret	Mari	e Ti		boh1
19a. INFORMANT'S NAME (Type/Print) Henry Kroll		19b. MAILING 805	Bear Ca	abin D	rive	Fore	n, State, Zij StHi	Code)	d.21050
20a. METHOD OF DISPOSITION 1 Surlel 2 Cremetion 3 Remova 4 Donation 5 Other (Specify)	of from State Co.	b. PLACE AND DATE of metery, crematory or o	ther place)		DA.				own, State
21. SIGNATURE OF FUNERAL SERVICE LICENS	SEE /	ak Lawn	Cemet.	Dry 12	/22/	94L Ba	1 t i n	iore	MD.
DR T	//	111,		e11y F					
A July	Jonne	lly	300 1	A CO A	WO	Ral+i	more	ME	21221
23. PART I. Enter the diseases, or con- ehock, or heart falling. Lis	t only one ceuse on	ech line	not entar the mo	de of dying, s	uch sa car	dlac or raspi	ratory ar	reat,	Approximata interval Between
iMMEDIATE CAUSE (Final disease or condition	1 win	0 1	1-11						Onsat and Death
resulting in deeth)	DUE TO OR AS	A CONSEQUENCE OF	1 M/						1-24,
	1			0 1	1.00	1-11	P	٩	12-1-
Sequentieily list conditiona, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF	gleme		248 15	1 /20	المال	rt.	1, 2
cause. Enter UNDERLYING CAUSE (Disease or Injury	Osto	allets	& len	w					2 ~ 31-
thet initieted events	DUE TO (OR AS	A CONSEQUENCE OF	F)!						
resulting in death) LAST									
PART II. Other aignificent conditions of	ontributing to deeth	but not reculting	in the underlying	g cause given	in Part i.	24s. WAS AN	AUTOPSY	24	D. WERE AUTOPSY FINDINGS
1						PERFOR			AMILABLE PRIOR TO COMPLETION OF CAUSE
						1 TYES 2	□ NO		OF DEATH?
DID TOBACCO USE CONTRIB	SUTE TO CAUSE (OF DEATH YE	S [] NO [UNCERT	AIN []				1 TES 2 NO
25. WAS CASE REFERRED TO MEDICAL		28. PLACE OF DEAT		J OITCER!					
	IOSPITAL:	patient 3 DOA	OTHER: 4 Nursing Hom	e 5 Reelden	ca 6 Oth	er (Specify)			
27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIM	IE OF 28c. INJ		_	SCRIBE HOW I	NJURY OC	CURED	
1 Natural 5 Pending 2 Accident Investigation	(month, buy, rout)	1113		ES 2 NO					
3 Suicide 6 Could not be	26e. PLACE OF INJUR building, atc. (Spe	Y — At home, term, a	street, factory, office		261. LO	CATION (Street a	and Number	r or Rural	Route Number,
4 Homicide determined					J. Jany	- rowr, orate)			
	N: To the best of my know								
29b. SIGNATURE AND TITLE OF CERTIFIER			y opinos, o	29c. LICENSE		erru piece, BN			a) and manner as stated. O (Month, Day, Year)
	09			D.	- 142	2/	> /	12.	19.94
30. NAME AND ADDRESS OF PERSON WHO C	OMPLETED CAUSE OF DI	23 FACT	Print) PRN J	RIVD	Ba	170	Un	2	1201
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	NATURE		NAT ()	4 14	_1011	10.	-	1001
DEON O NOT JUN									

YEAR

USA

Specify

3. TIME OF DEATH

8:30

8. BIRTHPLACE (State or Foreign Country)

Pennsylvania

10d. INSIDE CITY

14. RACE — American Indien, Black, White, atc.

1 YES 2 NO

White

21060

Approximata

24b. WERE AUTOPSY FINDINGS

1 YES 2 NO

AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH?

Interval Between

Onset and Daath

2. DATE OF DEATH MONTH

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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SION OF VITAL RECORDS, I	i

Bennett Dec. 1994 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day. Year) Sept. 8,1926 1 🗌 M 2 😿 F YRS. 179-20-7561 68 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 6609 Rapid Water Way, Unit 103 DIRECTOR Glen Burnie Anne Arundel RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION Maryland Anne Arundel Glen Burnie permit. 10e. STREET AND NUMBER FUNERAL 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6609 Rapid Water Way, Unit # 103 hours after death. Page 6 may be retained by the hospital or attending physician. It is the funeral director, page 5 should be detached for use as the burial-transit 21060 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Maxicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced 8 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY ET Elementary/Secondary (0-12) College (1-4 or 5+) COMPL Registered Nurse Hospital 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) N Turner Austin Bell Grace E. Keech notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Margaret L. Bennett 205 Water Fountain Ct., #101 Glen Burnie, MD pe 20a. METHOD OF DISPOSITION

1 Buriel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State must Metro Crematory, Inc. 4 □ Donation 5 □ Other (Specify) 12/17 Baltimore, MD 21. SIGNATURE OF FURERAL SERVICE LIGHNSES medical examiner 22. NAME AND ADDRESS OF FACILITY Cremation Society of Md., Inc. George E. MacNabb 299 Frederick Rd. Balto. n and completely filled in by the to burial, cremation, or removal. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock. Dr haart failure. List pniy one cause on each line **IMMEDIATE CAUSE (Final** the 57 the stomech with metastast disease or condition resulting in death) Carreer o event, DUE TO (OR AS A CONSTQUENCE OF) traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, laading to immediata physician certificate be cause. Entar UNDERLYING CAUSE (Disease or injury Injury, or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events the attending p resulting in death) LAST PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY MEDICAL een signed by the shows any 1 TYES 2 NO peen DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES INO I UNCERTAIN I PHYSICIAN: has be Dept. 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) tertificate h HOSPITAL: OTHER:
4 | Nursing Home 5 | Residence 8 | Other (Specify) 1 YES 2 NO 1 Dinpatient 2 ER/Outpatient 3 DOA 0 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) MIS O 28b, TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 1 YES 2 NO ECTOR: After IT is after death i BY 2 Accident Investigation 28a. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 38 8 Could not be COMPLETED 4 Homicide 58 datermined 29s. CERTIFIER
(Check only) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner ea stated. 29b. SIGNATURE AND TITLE OF CERT 29c. LICENSE NUMBER BE Culyare Sonce My D16619 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Corazon Vergara-Soares, M.D. 100 N. Broadway Baltimore, MD

July 32 Michigan Revolute

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

B.

29d, DATE SIGNED (Month, Day, Year) 12/17/94 DHMH-18 Rev 1/89

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ear frours after death. Page 6 may be retained by the hospital or attending physician.	1
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. The filled within 72 hours after death with the State Debt, of Health and Mental Hydiene prior to burial, cremation, or remand.	1
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COMPLETED

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94 37480 IYEMS: 1. & 8. PER F.H. FILM G-718 12/20/94 t.t FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DEC 19 1894 YEAR 3. THE OF DEATH BUSWELL HOLT W. BUSWELL, JR 4. SOCIAL SECURITY NUMBER 5 SEY 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BURTH 8. BIRTHPLACE (State or Foreign or 24, 1923 216-18-3992 1 🕅 M 2 🗌 F 71 HOURS YRS. Aug New Hampshire 9s. FACILITY NAME (If not institution, give street and number, 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH
Baitimore Towson, Maryland DIRECTOR Saint Joseph Hospital RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY
LIMITS?
THE YES 2 NO Maryland Baltiomre 10e. STREET AND NUMBER FUNERAL 10f. ZIP COOE 10g, CITIZEN OF WHAT COUNTRY? 1450 Redfern Avenue 21211 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1X XYES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, Whits, stc. 1 Never Married Married If yes, specify Cuban, Maxican, Puarlo Rican, etc.)

1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES 1 - YES 2 NO BY Specify: White 3 Widowed 4 Divorced WWIT COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INQUISTRY (Specify only hig (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) 1 2 Personnel Director Manufacturing 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Holt Winn Buswell Minna Berger BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ACCRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ILING ACCRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21211 1450 Redfern Avenue, Baltimore, Maryland 2 Katharine Buswell Valley Memorial 2/22 20ex METNOD OF DISPOSITION

1 Burlel 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of 20c. LOCATION - City or Town, State Dulaney 4 Donation 5 Other (Specify) Cockeysville, Maryland 21. SIGNATURE OF FUNERAL SERVICE ZICENSEE Burgee-Henss Funeral Home 21211 Hacey inlle ar 3631 Falls Road, Baltimore .Maryland 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, shock for heart failure. List only one cease on each line. Approximete interval Between IMMEDIATE CAUSE (Finsi Onset and Death disesse or condition . METASTATIC NON SMALL CELL LUNG CARCINOMA 2 MOS. resulting in deeth) QUE TO (OR AS A CONSEQUENCE OF) PANCYTOPENIA SECONDARY TO CHEMOTHERAPY CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATN? PERFORMED' **ASCITIS** 1 TES 2 THO 1 TES 2 THO PHYSICIAN: DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES TO NO UNCERTAIN

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) OTHER: patient 2 - ER/Outpatient 3 - DOA

1 - YES 2 - X6 27 MANNER OF OFATN 1 Accident

29b. SIGNATURE AND TITLE OF CERTIFIER

4 Nomicide

29e. CERTIFIER

5 Pending Investigation 3 Suicide 6 Could not be

determined

28e. DATE OF INJURY (Month, Day, Yeer) 28b. TIME OF INJURY 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, stc. (Specify)

4 - Nursing Nome 5 - Residence 8 - Other (Specify) 28c. INJURY AT WORK? 1 YES 2 NO

29c. LICENSE NUMBER

D 41410

26d, DESCRIBE NOW INJURY OCCURED

281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29d. DATE SIGNEO (Month, Day, Year)

12

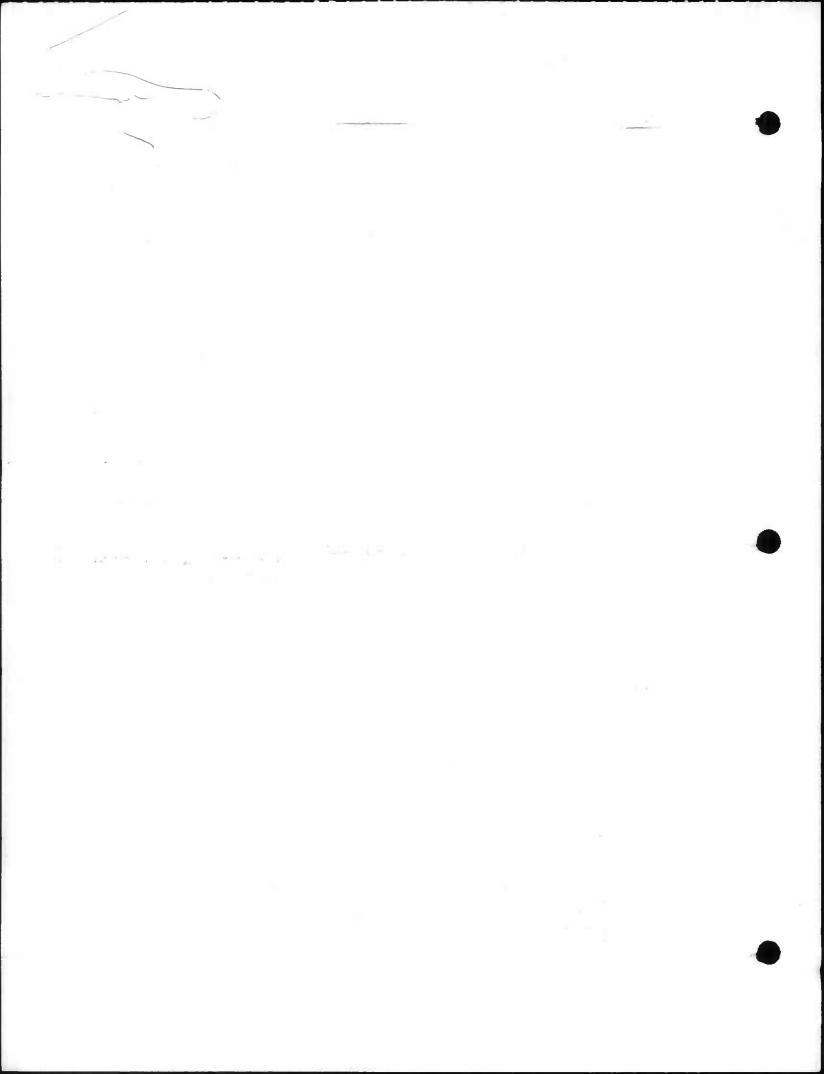
1 PRTIFYING PNYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 _ MEDICAL EXAMINER: On this basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(s) and manner as stated.

of andu Ea 30. NAME AND ADDIES OF FRON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type,

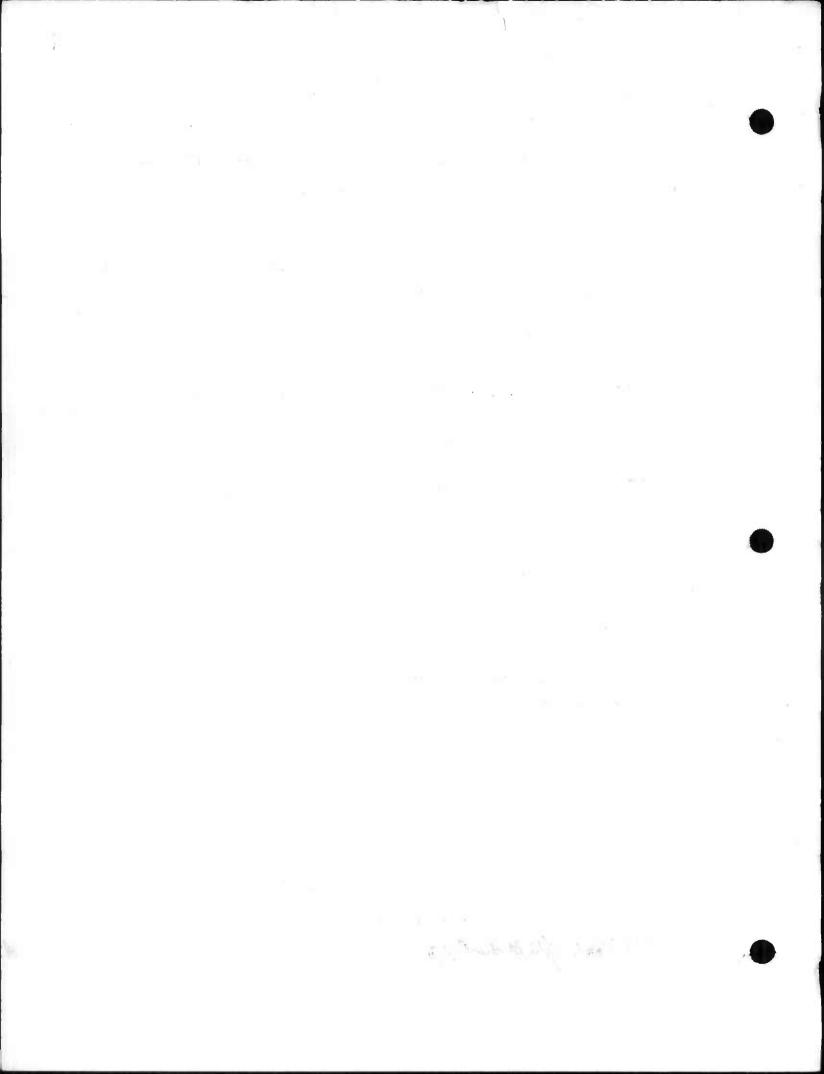
MD JOGINDER P. MEHTA, M.D., 7620 YORK ROAD, TOWSON, MD. 21204

Julia relaminenchande II



		1 - FOR STATE OF MARYLAND / DEPARTMENT OF CERTIFICATE OF CERTIFICA	HEALTH AND ME	NTAL HYGIENE REG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last)		DATE OF DEATH DAY 1994	YEAR 3. TIME OF DEATH 11:15 A M
	1 9	4, SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdey) F UNDER 1 YEL 1 1 M 2 F 32 YRS. MONTHS DAY	R IF UNDER 24 HRS. 7.	DATE OF BIRTN (Month, Day, Year)	B. BIRTNPLACE (State or Foreign Country)
should		9e. FACILITY NAME (If not Institution, give street end number) 9b. CITY, TOW	N OR LOCATION OF DEATH	FEB. 17 1962 N 9c. COUNT	M D TY OF DEATN
1, 2, 3 ;	TOR	M'D GENERAL HOSPITAL BAG	LIMOR	E	
Pages	DIRECTOR	10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LO	CATION RE		10d. INSIDE CITY UMITS? 1 YES 2 NO
it permit.		100. STREET AND NUMBER 1518 DAKER ST.	101. ZIP CODE	10g. CITIZE	EN OF WHAT COUNTRY?
020 physician. burial-transit	FUNERAL	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED 13. WAS	DECENDENT OF NISPANIC (specify Cuben, Mexican, P	ORIGIN? (Specify Yee or No 1	14. RACE — American Indian, Black, White, etc.
oding s the	В		YES 2 NO Specify:	de la riceri, etc.)	Specify: BLACK
_ ~ 3	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUP (Give kind of work done during life. Do NOT use retired.)	most of working	16b. KIND OF BUSINESS/INDU	STRY
	OMPL	12-th Unknow 17. FATNER'S NAME (First, Middle, Last)		(First, Middle, Maiden Surname)	
MARYLAND 2- retained by the hospital o 5 should be detached for notified at once.	BE C	DONALD W. SMITH	PAME	LA BANK	<2
5 5 5	2	PAMELA BANKS 8CHARLES	PLAZA #1	e Number, City or Town, Stete, Zip C 1407 Nol TH	DALTO, MD
ORE, e 6 may be ector, page		20a METNOD OF DISPOSITION 1 Suriel 2 Cremetion 3 Removal from State 4 Donation 5 Charles (Specify)	(Name of Pu	DATE 20c. LOCATION - CH	0 11 1 6
- 00 E		21. SIGNATURE OF FUNERAL SERVICE LICENSES	AND ADDRESS OF FACILITY		(13/2 1)
BALT hours after death, of in by the funera or removal.	-	23. PART I. Enter the diseases, or complications that caused the death. Do not entar tha	00 wa		st, Approximate
fiffed in or he me		immediate Cause (Finel			Interval Between Onset and Death
3760, tred with completely fill ial, cremation, event, the		resulting in death) DUE TO (OR AS A CONSEQUENCE OF):			unknown
execute and cand can buria	NOI	Sequentially list conditions, if any, leading to immediate Congestive Heart Fa	ilure		
Co to to to	CERTIFICATION	cause. Enter UNDERLYING CAUSE (Disease or Injury thet initiated events HIV, Cardiomyopathy Due To (OR AS A CONSEQUENCE OF):			
S, P.O. death certific attending permal Hygien ury, or other	ERTI	resulting in death) LAST			
RDS at the d by the and Me y Injur	13	PART II. Other significent conditions contributing to deeth but not resulting in the underly Mycobacteruim Avium Complex	ing ceuse given in Per	t I. 24s. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
AL RECOR he law requires that has been signed by e Dept. of Health an	MEDICAL	Terminal Aids		1 TYES AND	COMPLETION OF CAUSE OF DEATH?
ITAL R ITAL R It The faw re cate has bee State Dept. o	IAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only o			
	PHYSICIAN:	EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ZER/Outpatient 3 DOA 4 Nursing N	iome 5 Reeldence 8 -	Other (Specify)	
	ВУ РН	(Month, Day, Year) INJURY	INJURY AT 284 WORK?	d. DEŞCRIBE NOW INJURY OCCU	RED
PA	8	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At home, ferm, street, factory, o building, etc. (Specify)	ifice 281	t. LOCATION (Street and Number or City or Town, State)	Rural Route Number,
A PART E	APLET	29e. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, d			
TO THE PARTIES IN POSTANT: If	COMPL	2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion 29b. SIGNATURE AND TITLE OF CERTIFIER	1, death occured at the time		cause(e) end menner es stated. SIGNED (Month, Day, Year)
5 5 5 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	TO BE	Jospanie 3 maise	89209		2/16/34
		30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) Josephine Waite, M.D. c/o Marylar	nd General	. Hospital	
		DEC2 0 1094 William Musiker Royal .			
,					DNMH-18 Rev 1/89

DNMH-18 Rev 1/89



21215-0020	
MARYLAND	
BALTIMORE,	
68760	

DIVISION OF VITAL RECORDS, P.O. BOX

		DEPARTMENT OF HEALTH AND I	MENTAL HYGIENE REG. NO.	
,	1. DECEDENT'S NAME (First, Middle, Last) GEORGE OLIVER BROWN	,	2. DATE OF DEATH MONTH DAY 12 14	YEAR 1:45 PM
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. Is: 705 - 05 - 8440 1 M 2 - F 87	St birthdey) FUNDER 1 YEAR FUNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Morth, Day, Year) 1907	8. BIRTHPLACE (State or Foreign Country) Maryland
CTOR	9a. FACILITY NAME (If not institution, give street and number) GODD SAMINETAN HOSPITAL RESIDENCE OF DECEDENT	9b. CITY, TOWN OR LOCATION OF DE	EATH 9c. COU	NTY OF DEATH
DIREC	10a. STATE 10b. COUNTY Maryland	10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 X YES 2 NO
AL	10e. STREET AND NUMBER 4752 Al.hambra Avenue	107. ZIP CODE 21212	10g. CITI	ZEN OF WHAT COUNTRY? USA
BY FUNER	11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 YES 2 MIFYES, GIVE WAR OR DATES	RMED 13. WAS DECENDENT OF HISPAN	n, Puano Rican, etc.)	14. RACE — American Indian, Black, White, atc. Specify:
LETED	(Specify only highest grade completed)	ECEDENT'S USUAL OCCUPATION live kind of work done during most of working . Do NOT use retired.)	16b. KIND OF BUSINESS/IND	Black
COMPL	17. FATNER'S NAME (First, Middle, Last)	ed Cap Porter 18. MOTHER'S NA	B & O Ra ME (First, Middle, Maiden Surname)	ailroad
O BE		Mary b. MAILING ADDRESS (Street and Number or Rural I		
	20a, METHOD OF DISPOSITION 1 Note: A second of the second	4752 Alhambra Aver ANDDATE OF DISPOSITION (Name of Breefory or other place) CUS Memorial Park	DATE 20c. LOCATION	
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FA 2501 Gwynns F Baltimore, Ma	GUTY Nutter Funer	cal Homes, Inc
	23. PART I. Enter the diseases, or complications that caused the de ahock, or heart fallure. List only one cause on each line IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSE	ACLEOSIS OUENCE OF):		Interval Between Onset and Death
CERTIFICATION	Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. SETS/S DUE TO (OR AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSEC		BACTEXEM	JA.
MEDICAL	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEA	BONG METASTAS,	PERFORMED? 1 VES 2 NO	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2
HYSICIAN:	EXAMINER? 1 YES 2 NO 1 Inpetiant 2 ER/Outpatient 3 27. MANNER OF DEATH 28a. DATE OF INJURY	OTHER: DOA 4 Nursing Nome 5 Residence 28b, TIME OF 28c, INJURY AT	8 Other (Specify) 28d. DESCRIBE NOW INJURY OCC	CURED
б ву Р	1 Netural 5 Pending (Month, Day, Year) 2* Accident 5 Investigation 3 Suicide 8 Could not be 28s. PLACE OF INJURY — At he building, etc. (Specify)	INJURY WORK? 1 YES 2 NO me, ferm, streat, factory, office	28f. LOCATION (Street and Number City or Town, State)	
7	29a. CERTIFIER (Check only CERTIFYING PNYSICIAN: To the best of my knowledge, de	eth occurred at the time, date and place, and due		od.
COM	2 MEDICAL EXAMINER: On the beele of axamination end/or		time, data and place, and due to the	
TO BE	30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITE)	P0807		2.14.94
	FADI SABA, GOOD SAMARI	TAN HOSPITAL BA	crimores, MD	2/23%
	31. DATE FILE OF 1994 July 22. A CHARLES STATE OF THE STA			

TO BE COMPLETED BY FUNERAL DIRECTOR

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TO THE HIGHER CONTENTS PHYSICIAN: The law requires that the death certificate be executed within 29 hours after death. Page 6 may be retained by	TO THE HINEM. DHECHE IN THIS certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should by he find	IMPORTANT II The confirmation of the 23 shows any injury, or other traumatic event, the medical examiner must be notified at
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is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR		SINIE UF MANT			IENT OF H ATE OF	IEALTH AND I	MENTAL	REG. NO.	E		
1. DECEDENT'S NAME (First,	Middle, Last)						2. DATE (OF DEATH			3. TIME OF DEATH
Margaret	Anna						Dece	ember ^m	17 9	34R	8;55 A. M
4. SOCIAL SECURITY NUMB 216-07-0810		SEX 6. AGE	(In yrs. last		UNDER 1 YEAR	IF UNDER 24 HRS. HOURS MIN.	7. DATE C (Month,	Day, Year)		Country)	LACE (State or Foreign
9a. FACILITY NAME (# not int			86.		CITY TOWN (OR LOCATION OF DI		ber 10,	1908 9c. COUNT		ryland
Manor Car						son	CAIH			timo	
10a. STATE	10b. COUNTY			10c. CITY, TO	OWN OR LOCAT	TION				- 13	10d. INSIDE CITY
Maryland	Harfo	rd		Bela	ir					-	1 TES 2 X NO
10s. STREET AND NUMBER				_	101	. ZIP CODE					HAT COUNTRY?
2427 Cool S						21015				U.S.	
1 Never Married 2		2. WAS DECEDENT EVER FORCES? 1 YES	2 X N	WED O	II yea, sp	ENDENT OF HISPAN ecify Cuban, Mexico	n, Puerto R		or No-	Black,	— American Indian, White, atc.
3 Widowed 4 Divor	rced	IF YES, OIVE WAR OR	DATES		1 YES	2 NO Specif	γ.			Specify	White
	EDENT'S EDUCAT		18a. DE0	CEDENT'S USU	AL OCCUPATION	ON est of working	16b.	KINO OF BUS	INESS/INOUS	STRY	MILLE
Elementery/Secondary (0-	-12)	Cotlege (1-4 or 5+)	life.	Do NOT use rel	ired.)	or or working					
17. FATHER'S NAME (First, Mi		3 yr's	<u> </u>	<u>omemak</u>	er_				<u>Home</u>		
Frank	odie, Last)	Цi	lsher			18. MOTHER'S NA		iddle, Maiden 3		0 10 0 m	
19a. INFORMANT'S NAME (7)	rpe/Print)	111.		MAILINO ADI	ORESS (Street a	Marga and Number or Rural		or City or Town		orem	Idn
Mr. Ralph J	. Hilsh	er		Same a				or, only or rown	, 0.00, 2,0	000)	
20a. METHOD OF DISPOSITION 1 💢 Burial 2 🗆 Cremetto	ON	20	b. PLACEA	NODATEOFD	SPOSITION (Ne	me of	OATE	20c. LOC	CATION — CH	ly or Tow	n, State
4 Donation 5 Other	(Specify)		metery, crer	Parkwo	od Cer	n. 12/20	0/94	Bal	timor	e, M	1d.
21. SIGNATURE OF FUNERAL	SERVICE LICEN	Paul L. Ha	artsoc	k .Tr	22. NAME AN	ID ADORESS OF FA		Baltim			
Haw I	Haits	achetr	AI 0000	, 0, .	Leona	ard J. Ri					
23. PART I. Enter the dis	seeses, or con	nplications that cause	d the dea	th. Do not	ont at the me		A CIC L	110.	7000 11	uiic	
		t only one nauce on	annh lina		ritei the mo	de of dying, suc	n ss cerai	ac or respir	ratory arrea	it,	Approximete
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		t only one cause on	each iine.								Interval Between
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E. '

Include: The law requires that the death certificate be executed with Chours after death. Page 6 may be retained by the hospital or attending physician.

Confidente has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be based to use as the burial-transit permit. Pages 1, 2, 3 should be based by the attending physician prior to burial, cremation, or removal. **BALTIMORE, MARYLAND 21215-0020**

OF VITAL RECORDS, P.O. BOX 68760.

TO THE HOSPITAL UNITO THE FUNERAL DATA DE filed within 72 nour

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

		1. DECEDENT'S NAME (First		0.0								2. DATE OF DEATH			3. TIME OF DEATH
	Ì	WILLI		V BOG	9							12 10	DAY 9	YEAR	13.57 M
	*	4. SOCIAL SECURITY NUME		5. SEX	6. AGE (In y			IF UNDER 1 Y	EAR AYS	IF UNDE	R 24 HRS.	7. DATE OF BIRTH (Month, Day, Year	0.45	8. BIRT	
	ı	215-05-7098 9a. FACILITY NAME (If not in		11	/	77	YRS.	ah CITY YO	WW. 0	010047	1011 05 05	November:			MD
_ g	CIOR	9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Harbor Hospital Center Baltimore									DEATH				
5		RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION													
DIBE		MD Anne Arundel							OCATI	ON					10d. INSIDE CITY LIMITS?
	ENAL	10e. STREET AND NUMBER				Pasadena 101. ZIP CODE				10a CI	TIZEN OF	1 TYES 2 NO			
FRAI		224 Inlet Drive 21122 USA													
N		11. MARITAL STATUS		12. WAS DECEDEN	T EVER IN U.S	S. ARMI	ED			NDENT	OF HISPAN	HC ORIGIN? (Specify	Yea or No-	14. RAC	F American Indian
\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \		1 Never Married 2 Married FORCES? 1 YES 3 Wildowed 4 Divorced FORCES? 1 YES								2 XNO		n, Puerto Rican, etc.)		Spec	
1 00		15. DEC	EDENT'S EDU		16:	a. DECE	EDENT'S U	SUAL OCCU	PATIO	N		16b. KIND OF	RUSINESS/IN	DUSTEY	white
	: II	(Specify only Elementary/Secondary (0	y highest grade 0-12)	College (1-4 or 5		(Give	kind of wo	rk done durir	ng mos	t of world	ing	I TOO. KIND OF	JUSH4E39/114	DOSINI	
once.		8				Ele	ctri	cian				Bethl	ehem	Stee!	1
9 0		17. FATHER'S NAME (First, M.										ME (First, Middle, Maid		-	
B B	:	William Al		Bogy		405				<u> </u>		Christin			
be notified at once. TO BE COM	2	Diane E. Ge	,,									noute Number, City or adena, MD			
	ı	20a. METHOD OF DISPOSIT	ION		20b. PL	ACEAN	D DATE OF	DISPOSITIO	N (Nar	ne of	1 050		LOCATION -		own, State
E I		1 Surial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other	(Specify)		cemeter Ce	ry, creme dar	Hil	r place) Cem	ete	ery		12/19	Brook	lyn 1	Park, MD
mine	1	21. SIGNATURE OF FUNERA	L SERVICE LIC	en H. Wi				MCC	E ANI	V F	ss of fa	al Home c	f Pas	adena	a
exa			Steve	en H. Wil	lliams							Road, Pa			
or other traumatic event, the medical examiner must	23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or haert failure. Liet only one cause on sech line.											reat,	Approximate interval Between		
the m		IMMEDIATE CAUSE (Findisease or condition	nel	Dn	eumon	10									Onset and Deeth
eut,	H	resulting in death)	→	a	(OR AS A CO		ENCE OF):								
2 Z		- Metastatic Non-8mall all ling cardnomal													
ry, or other traumatic		Sequentially list conditi if any, leading to immed	diate	DUE TO	(OR AS A CO	NSEOU	ENCE OF):	. 1							
FIC T		CAUSE (Disease or inju			beter OR AS A CO	/ 4		rus							
to a		that initiated evente resulting in deeth) LAS	т	4	(İ
	- 11	PART ii. Other eignifice	ont condition	e contributing to	death but s	not rea	ulting in	the under	dulaa		-live to	Bank I av ma		T	
ows any injury, AEDICAL CI				o contributing to	Geetti Dat i	100 100	diting in	the under	iyiriy	Cause	given in	PERI	ORMED?	248	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE
E S												1 □ YES	2 NO		DF DEATH? 1 YES 2 NO
AN: R		DID TOBACCO U	SE CONTI	RIBUTE TO CA	USE OF D	DEATH	H YES	□ NC		UNC	ERTAIN	<u></u>			TES 2 NO
CIA CIA		25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)													
PHYSICI,		1 YES 2 NO		1 Inpetient 2			DOA 4		_	_	asidenca	8 Other (Specify)			
	- 10	1 Netural 5	Pending	28a. DATE OF (Month, D			28b. TIME (N .	WOR	FTY AT K? ES 2	¬ MO	28d. DESCRIBE HO	V INJURY OC	CURED	
is mar D BY		2 Sulpido	Could not be	28a. PLACE O	F INJURY — /	At home	, Jarm, stre					28f. LOCATION (Stre	et and Numbe	r or Rural I	Route Number,
원	Ш		detarmined	building,	atc. (Specify)							City or Town, Sta	(e)		
IMPORTANT: If item O BE COMPLE		29a. CERTIFIER (Check only	IFYING PHYSI	CIAN: To the beat of	my knowledge	e, death	occurred	at the time,	deta a	nd place	, and dua	to the cause(a) and a	nanner as ata	ited.	
		one) 2 MEDI	CAL EXAMINE	R: On the beals of a	camination an	d/or Inv	estigation,	In my opini	on, de	eth occu	red at the	lime, data and place,	and due to t	he cause(s	a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER PITAYADET JUMRUSSIRIKUL 29c. LICENSE NUMBER 29d. DATE SIGNED (Month)															
PITAYADET JUMRUSSIRIKUL AS 244-1614 > 12/14/94 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									14/94						
			RBOR	HOSPI	TAL	0	TR		AL	TIM	ORE	, MD	21	225	
		DEC2 0 18	184 A	32. REGISTA	R'S CHATU	34				·					
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130 E.Fort Ave

Approximata Interval Between Onset and Death

the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit I Mental Hygiene prior to burial, cremation, or removal.

permit. Pages 1, 2, 3 should

FUNERAL DIRECTOR

BY

COMPLETED

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notified at once.

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Injury, or other traumatic event, the medical examiner

CERTIFICATION

PHYSICIAN: MEDICAL

BY

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DIVISION OF VITAL RECORDS, P.O. BOX	28	Cia	6	6
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	TO THE HOSPITAL OF ATTENDING PAYSICIAN: The law requires that the death certificate be e	TO THE FUNERAL URRECTION TO THE CONTROL OF THE FUNERAL URRECTION OF THE FUNERAL URRECTION OF THE FOREST OF THE FOR	flec	Š
	2	2	9	IMPORTANT: If It is 28 is marked, or Item 23 shows any Injury, or other traun
	-	-	4.3	_

FOR STATE REGISTRAR		STATE OF N	IARYLA	AND /	DEPAR	TMEN	T OF I	DEA	AND I	MENTAL HYGIE			
1. DECEDENT'S NAME (First,	, Middle, Last)								-	2. DATE OF DEATN			3. TIME OF DEATN
HOWAR	DI	BE	M	An	LAN	/				MONTH 12	DAY (2	94	10.30 1
4. SOCIAL SECURITY NUME	BER	5. SEX	6. AGE (n yrs. last	. ,,		R 1 YEAR	-	R 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		S. BIRTH	IPLACE (State or Foreig
220-09-863	38	1 № M 2 🗆 F		83	YRS.	MONTHS	DAYS	HOURS	Min.	10/21/	11	Ma	ryland
9a. FACILITY NAME (If not in	stitution, give s	treet and number)				9b. CIT	Y, TOWN	OR LOCAT	ION OF DE	EATN	9c. CO	UNTY OF D	EATN
Harbor Hospital Center					В	alt.	o.Md						
10a. STATE	10b. COUNTY	1			10c. CIT	Y, TOWN	OR LOCA	TION					10d. INSIDE CITY
Maryland					В	alt	o.C	ity,	Md.				LIMITS?
10e. STREET AND NUMBER							10	f. ZIP COD	E		10g. CI	TIZEN OF V	WHAT COUNTRY?
119 E	Gitt.	ings St	٠.					2	123	0	Uni	lted	States
11. MARITAL STATUS		12. WAS DECEDEN				13				NIC ORIGIN? (Specify		14. BACI	- American Indian,
1 Never Married 2	Married	FORCES? 1 IF YES, GIVE W			U		It yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 YES 3 NO Specify: Specify:						k, White, etc.
3 Wildowed 4 Divorced W.W.2								2626					White
15. DECEDENT'S EDUCATION 18e. DECEDEN (Specify only highest grade completed) (Give kind				re kind of	work done	during m	ON ost of work	ing	16b. KIND OF	BUSINESS/IP	OUSTRY		
Elementary/Secondary (0		College (1-4 or 5 d	-)	IIIo.	Do NOT u							_	
10th.Grade					Mill Worker E					Bet	nlehe	em S	teel Co.
17. FATNER'S NAME (First, M	liddle, Last)							18. MO1	NER'S NA	ME (First, Middle, Maid			
	Johr	1			nam							er	
19s. INFORMANT'S NAME (7	ype/Print)			19b						Route Number, City or			
Mrs.Hilda	и. М. В€	ennaman			119	Ε.	Git [.]	ting	s S	t.Balto	.Md.	212	30
20a. METNOD OF DISPOSIT	ION	ovel from State	20b.	PLACEA	NDDATE	OF DISPO	SITION	ame of		OATE 20c.	LOCATION -	- City or To	rwn, State
4 Donation 5 Other	(Specify)	Over Holli State	Ğ1	enery, cren	Hav	en er piace	Mem	.Pk.	12/	16/94 G:	len E	Burn	ie,Md.
21. SIGNATURE OF FUNERA	L SERVICE LIC	CENSEE	//	1		22	. NAME A	ND ADDRE	SS OF FA	CILITY Balto	o.Md.	212	30
· Lan	ist	a 1/1	221	ba			McC	u11y	Fu	neral Ho	ome,	130	E.Fort A
23. PART I. Enter the di shock, or h	iseases, or c aart fallure.	complications tha List only one cay	t caused sa on ea	tha dea	th. Do	not anta	r tha mo	oda of dy	ring, suc	h as cardiac or re	spiratory a	rrest,	Approximata interval Betw
iMMEDIATE CAUSE (Fir disease or condition	nal	(1	120	10/	^	AC	-110	TAI					Onset and Di
resulting in death)	→	CA					3	101	_ (
		DUE TO	(OR AS A	CONSEO	UENCE O	F):							
Sequentially list conditi	lons,	ь.	CY-	17									
		DUE TO	(OR AS A	CONSEC	UENCE O	P):							

Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

GRONIC

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ditio	ns :	contributing	to	daath	but	not	result	ing in	the	underlying	cau	se	given	in	Part	į
61	39	STRUC		TIV	E		4)/V	a	De	5	6	A	2	6	

HEART

-CER.

24a. WAS AN AUTOPSY PERFORMED? DISEA

AS 2441614-18

FAILURE.

24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 HO 1 YES 2 NO

12/12/94

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES TO NO TO LINCEPTAIN ITY

CONGESTIVE

AT MANUED OF BEATH										
EXAMINER?	HOSPITAL: 1 1 Input lant 2 ER/Output 3	OTHER:	5 Realdence	6 Other (Specify)						
25. WAS CASE REFERRED TO MEDICAL	26. PLACE OF DEATN (Check only one)									
DID TODACCO OSE COTT	RIBOTE TO CAUSE OF DEA		UNCERIAII	A [75]						

27. M/ 1 Natural

PART ii. Other significant conditions contr

2 Accident 3 Suicide determined

1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, building, atc. (Specify)

28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

INTERN Vamantheros MD

WNO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) TALCALRETTUU INTERN

HARBOR HOSPITAL CTR, BOOL, S HAMOUER ST

31. DATE FILED (Month, Day, Year) 22. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

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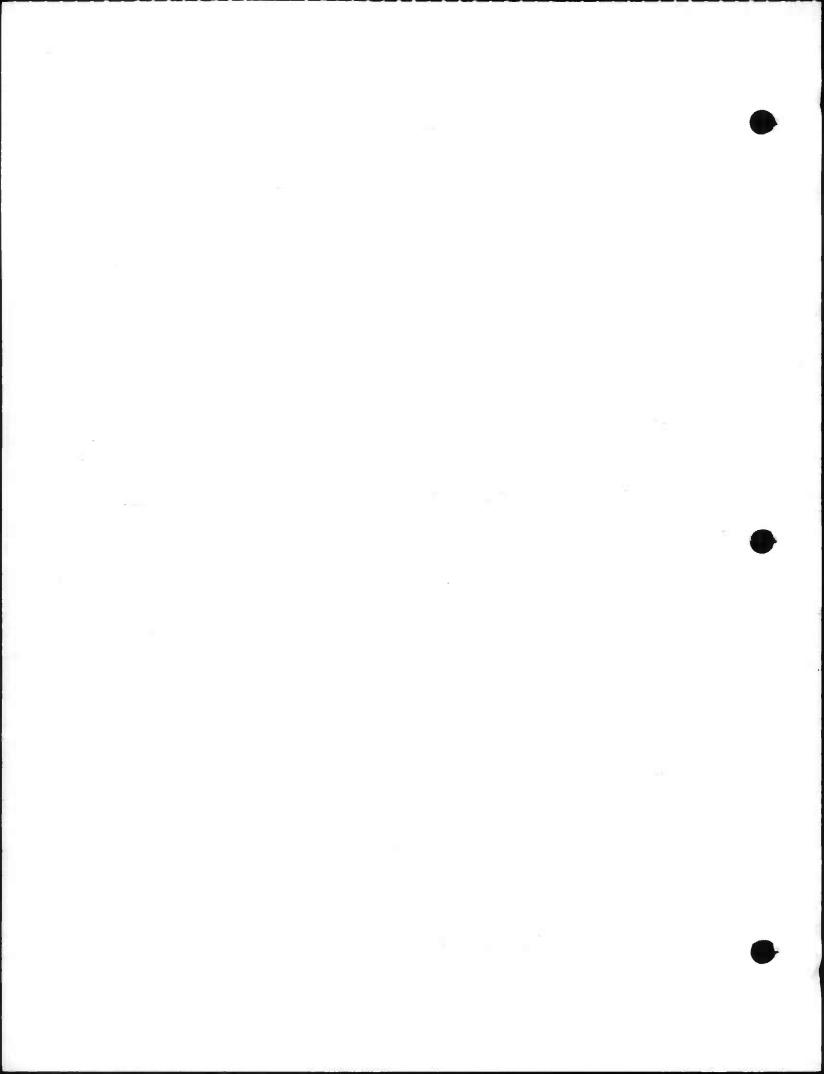
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within. Jours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be the four after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

WPDRTANT II from 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY FUNERAL DIRECTOR BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760, COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF	HEALTH	AND	MENTAL	HYGIENE
CERTIFICATE OF	F DEAT	TH		REG. NO.

FOR STATE REGISTRAR	STATE OF MARY	LAND / DEPARTI CERTIFIC	MENT OF H	EALTH AND I	MENTAL HYGIEN	_			
1. DECEDENT'S NAME (First, Middle, Last)	0				2. DATE OF DEATH	-	3. TIME OF DEATN		
JOSEPH RO	DY ISRAD	BERRY			MONTH D	5 9	4.00 P M		
4. SOCIAL SECURITY NUMBER	1 1	. ,	F UNDER 1 YEAR	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)	0. B	BIRTHPLACE (State or Foreign country)		
215-09-3561 90. FACILITY NAME (If not institution, give		94 YRS.	22	PR LOCATION OF DE	July 7, 1	900	Je orgia		
St. Agnes Hospit	,	l,		altimore	ATN	9c. COUNTY	OF DEATH		
RESIDENCE OF DECEDENT									
Maryland 10b. COUNT	Baltimore	19c. CITY, 1	rown or Locat	onsville		10d. IN LI 1 v			
100. STREET AND NUMBER 104 Oakdale Aven	ue	· · · · · · · · · · · · · · · · · · ·	101	. ZIP CODE 21228	2		OF WHAT COUNTRY?		
11, MARITAL STATUS	12. WAS DECEDENT EVER	IN U.S. ARMED	12 WAS DEC		IC ORIGIN? (Specify Yes				
1 Never Merried 2 Married	FORCES? 1 YES	2 NO	If yes, spe	ecify Cuben, Mexica	n, Puerto Rican, atc.)		RACE — American Indian, Black, White, etc.		
3 Wildowed 4 Divorced	T TES, GIVE THAT ON	DATES	I TES	2 NO Specify			Specify: White		
15. DECEDENT'S EDI (Specify only highest grad		tee. DECEDENT'S US	k done during mo	ON st of working	16b. KIND OF BU	SINESS/INDUST			
Elementary/Secondary (0-12)	College (1-4 or 5+)	life. Do NOT use r	etired.)		No. of the		4.4		
12 17. FATNER'S NAME (First, Middle, Last)		Securit	y Guard			n Marie	etta		
John A. Bradberr	Y			Nancy F	ME (First, Middle, Meiden Iaines	Surneme)			
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING AL	DRESS (Street a	nd Number or Rural F	loute Number, City or Tow	n, State, Zip Code	" 7 04 000		
Charles H. Bradb	erry (Son)	104 Oa	kdale A	Avenue Ca	tonsville	Maryla	and 21228		
20e. METNOD OF DISPOSITION 1 Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory 12-16-94 Catonsville Marylabd									
4 Donation 5 Other (Specify)	CENSEE	Metro Crem		IZ-10-94		onsvill	e Marylabd		
· Commen	(-)	1				zke Fun	neral Homes		
On DADE LE TONIA		7	1630 F	dmondsor	Avenue C	atonsvi	lle Maryland		
23. PART I. Enter the diseases, or shock, or heart fellure.	List only one ceuse on	esch line.	enter tha mo	da of dying, suci	n as cardiac or respi	ratory arrast,	Approximate Interval Between		
IMMEDIATE CAUSE (Finel disease or condition	A. t. S	9	-	Post	20		Onset and Death		
resulting in death)	a. DUE TO (OR AS	A CONSEDUENCE OF):	uhon	of (0	617		2 days		
	a Melling						2 2		
Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF):					· · ·		
CAUSE (Disease or Injury	COUE TO (OR AS	A CONSEQUENCE OF:							
that initiated events resulting in death) LAST		A CONSEQUENCE OF);					į į		
	d								
PART II. Other significent condition	ne contributing to deeth		the underlying	cause given in	Part I. 24a. WAS AN PERFOR	AUTOPSY IMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO		
COPD / Congents			DI TICUS	CVA	1 _ YES 2	□)(o	COMPLETION OF CAUSE OF DEATH?		
202100000000000000000000000000000000000							1 YES 2 NO		
DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CAUSE (UNCERTAIN	1 🗆				
EXAMINER?	HOSPITAL:		THER:						
27. MANNER OF DEATH	1 Inpatient 2 ER/Out 28e. DATE OF INJURY	28b. TIME O		5 Reeldence	8 Other (Specify) 26d, DESCRIBE NOW II	I II IBV OCCUBE			
1 Natural 5 Pending	(Month, Day, Yeer)	INJUR	Y WO		200. DESCRIBE NOW II	NJOHT OCCURE			
2 Accident investigation 3 Suicide 8 Could not be	28e. PLACE OF INJUR	Y — At home, ferm, stre			28f. LOCATION (Street of	and Number or Ru	iral Route Number,		
4 Nomicide determined	building, etc. (Spe	эсну)			City or Town, State)				
	ICIAN: To the best of my know								
2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(e) and menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day Year)									
111140	int			AO 15	97	▶ 12	NED (Month, Day, Year) \$15/9/4		
30. NAME AND ADDRESS OF PERSON WI				100		*			
	O COMPLETED CAUSE OF D	EATN (ITEM 27) (Type, Pri	nt)		= + 0 0	01	1 0 1		
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGN	Techiere	ST A	gues Ho	nutul Bo	althuor	e Maryland		



blh

ISPTILL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 26 hours after death. Page 6 may be retained by the hospital or attending physician.

THE DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be considered with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

THE IREM 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

	1 - STATE REGISTRAR	STATE UF MAI			OF DEAT		REG. NO.	E			
	1. DECEDENT'S NAME (First, Middle, L	ichn BE	en Ker-	t			2. DATE OF DEATH MONTH DA	٧	YEAR	3. TIME OF DEATH	
	4. SOCIAL SECURITY NUMBER 215-80-2425	5. SEX 6.	AGE (In yrs. lest birthday) 26 YRS.	IF UNDER 1 Y	EAR IF UNDER	MIN.	DATE OF BIRTH 18. (Month, Day, Year) July 17,1968			PLACE (Stelle or Foreign	
	9e. FACILITY NAME (If not institution, g	ive street and number)		9b. CITY, TO	OWN OR LOCATION				NTY OF D		
08	1226 Voght Av	enue		Arb	utus			Ва	ltin	nore	
DIRECTOR	10a. STATE 10b. CO	UNTY	10c. CIT	Y, TOWN OR I						10d. INSIDE CITY	
		Baltimore		Cator	sville				LIMITS? 1 YES 2 NO		
FUNERAL	100. STREET AND NUMBER 6112 Edmondson	pt.		101. ZIP CODE	1228				vhat country? .A.		
BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced	VER IN U.S. ARMED YES 2 X NO OR DATES	If yo			C ORIGIN? (Specify Yee Puerto Rican, etc.)	ORIGIN? (Specify Yee or No— Black, White Specify: W				
	15. DECEDENT'S (Specify only highest of		18a. DECEDENT'S	USUAL OCCL	IPATION ng most of workin		16b, KIND OF BUS	INESS/IND	USTRY		
COMPLETED	Elementery/Secondary (0-12)	College (1-4 or 5 +)	life. Do NOT u	se retired.)		¥					
MP	10 17. FATHER'S NAME (First, Middle, Last		Drywall	Mecr	nanic		Cons		tion		
	Gerard George Be					ith S	E (First, Middle, Meiden : Smith	Sumame)			
BE	19e. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (S	treet and Number	or Rural Ro	oute Number, City or Town	, State, Zip	Code)		
임	Gerard G. Benker		6112	Edmond	dson Ave	enue	Catonsvil	le Ma	aryl	and 21228	
	20e. METHOD OF DISPOSITION 1 Subsurial 2 Cremetion 3 5 4 Donation 5 Other (Specify)	Removal from State	Metro Ci New Carrey	compto	3-37	12/2	DATE 20c. LOS	ATION —	City or To	wn, State Maryland	
	21. SIGNATURE OF FUNERAL SERVICE	E LICENSEE	18	22. NAI	ME AND ADDRES	S OF FACI	LITY				
	Kusse	eaon e	20				ell C Witz			e Marvland	
23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, ehock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Out TO (OR AS CONSEQUENCE OF):									Approximate Interval Between Onset and Daath		
CERTIFICATION	Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):										
MEDICAL	PART II. Other eignificent condi	tlone contributing to dea	eth but not resulting	In the unde	rlying ceuse g	lven in P	ert I. 24a. WAS AN RERFORI	MED?	24b.	WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? FES 2 NO	
	DID TOBACCO USE CO	NTRIBUTE TO CAUS	E OF DEATH YE	S NO	D UNC	ERTAIN				PUTES 2 NO	
CIA	25. WAS CASE REFERRED TO MEDICA EXAMINER?	HOSPITAL:	28. PLACE OF DEA	TH (Check only	one)						
HYSICIAN:	1 X YES 2 NO 27. MANNER OF DEATH	1 Inpatient 2 ER		4 Nursing			X Other (Specify) at				
գ ∥	1 Natural 5 Pending	(Month, Day, Y	bar) IN.	URY	C. INJURY AT WORK?	<	ENGLE CT	Bens	Ten	874880	
BÁ	2 Accident Investigati 3 Suicide 8 Could not	280 PLACE OF IN	JURY - At home, ferm,			-	281. LOCATION (Street a			of Her	
ETED	4 Homicide determine			98n			1266 Vi	SITA	ve 1	JEBUTUS	
OMP		HYSICIAN: To the best of my	knowledge, death occurr	ed at the time,) end manner as stated.	
3											
5		78			0.0	C.M.	Ε.		Dec	18 1994	
F	30. NAME AND ADDRESS OF PERSON	WHO COMPLETED CAUSE O								and 21201	
	DEC2 0 1994	THE PRESIDENCE	SIGNATURE				52525	-14			

DHMH-15 Rev 1/89

								. 07 11 2					IEG. NO.			
			1. DECEDENT'S NAME (First, Middle, Last)			1	300	de	OL			2. DATE OF	DEATH	Y (OF PY	3. TIME OF DEATH
			4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In	_		IF UNDER	_	IF UNDER	24 MDC	7. DATE OF E	эноты	>	77	LACE (State or Foreign
		- 4	217-12-5731	1 □ M 2XXF	75	yra. near	YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, De	y. Year) 12 10	110	Country)	Carolina
	pino		9a. FACILITY NAME (If not institution, give st		70			9h CITY	TOWN	OR LOCATI	ON OF DEA		13,13		INUT OF DE	
	3 should	띩	Carroll County Ge		snita	a]				inist					roll	AIII
	1, 2,	티티	RESIDENCE OF DECEDENT		ортос											
	ages	DIRECTOR	10a. STATE 10b. COUNTY					Y, TOWN C							18	10d. INSIDE CITY LIMITS?
	permit. Pages		Maryland Carro) 1			V	esum		ster						I ☐ YES 2 🕅 NO
		RAL	3628 Bixler Churc	sh Dood					1	of, ZIP CODI	€ L158			10g. CIT		IAT COUNTRY?
	physician. burial-transit	FUNER	11, MARITAL STATUS	12. WAS DECEDEN	T EVER IN	IC AD	MED	1.0.							USA	
020	physic		1 Never Married 2 XX Married	FORCES? 1	YES	2 XN		1 1	If yes, s	pecify Cuba	in, Maxican,	C ORIGIN? (S , Puarto Ricar	n, etc.)	or No-	Black,	– American Indian, White, afc.
O g g G G G G G G G G G G G G G G G G G								YES 2X XNO Specify:					Specify	White		
21	r attend use as	윤	15. DECEDENT'S EDUC (Specify only highest grade			16a. DE0	CEDENT'S	USUAL O	CCUPAT	ION nost of working	na	16b. KIN	D OF BUS	INESS/INI	DUSTRY	
21	for a	W	Elementary/Secondary (0-12)	College (1-4 or 5	+)	(Give kind of work done during in life. Do NOT use retired.) Homemaker						1.	Home			
LAND	he hospital o detached for once.	COMPLET	9th.			пи	lelliak	ret.		Tour source						
YLA	by the		Walter W. Hurley							No.	ra Be	ie (First, Middle 11e Ma	le, Maiden∶ ∃V	Sumame)		
MAR	retained by the hospital or 5 should be detached for u notified at once.	98	19a. INFORMANT'S NAME (Type/Print)			19b	MAILING	ADDRESS	S (Street			oute Number, C	3	r. State. Zir	p Code)	
		5	Mrs. Barbara Deck	cer		43	329 M	ladon	na	Road	Str	eett,	Mary	lanc	2115	54
ORE	after death. Page 6 may be y the funeral director, page noval. cal examiner must be i		20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Ramo	oval from Stata	20b. P	LACE A	ND DATE	OF DISPOS	ITION (A		14010	DATE			City or Town	
M	direct direct		4 Donation 5 Other (Specify)	ENDER O	Me	tro	Cren	her plece)		12/	/16/9		Ran	Ltimo	ore,Ma	aryland
ALTIM	death. Pag funeral di examiner		-1		1)						ral	Home	:	. 21087
BA	ter de the fu val.		G. T.	Kass												. 21087
			23. PART i. Enter the diseases, or cahock, or heart failure.	complications tha List only one cau	t caused i ise on eac	the dea	ath. Do r	not enter	the m	ode of dyl	ing, auch	as cardiac	or respli	retory an	rest,	Approximate Interval Batween
	filled ion, o		IMMEDIATE CAUSE (Final disease or condition	1/010	ح بيل	,.1	01	1	-01	rille	· Li	210				Onset and Death
0	completely filled in ial, cremation, or re event, the med	ŀ	reaulting in death)	DUE TO	(OR AS A C	ONSEG	UENCE OF	n.								hour
68760	ecuted ind com burial, c	2		AC	ste	1	nuc	ca	va	lial	I	nfa	eva	410	4	ĺ
OX 6	8 6 6	CERTIFICATION	Sequentially list conditions, if eny, leading to immediate	DUE TO	(OR AS A C	ONSEG	UENCE OF	า:						-		
BO	physician ne prior to	2	CAUSE (Disease or injury	COV	ona	ry	17	rre	ry	13	150	2050	8			
0	ot die	Ë	that initiated evants resulting in death) LAST	DUE 10	(OR AS A C	ONSEO	UENCE OF	7):								
Ф.	THE HA	Ü		d												1
SOF	of the	ÄL	PART II. Other significant condition.										. WAS AN A			VERE AUTOPSY FINDINGS
CORI	- N. S.	EDICAL	Flow limitin	arter	205 K		in	/6	o C	- 17.	nary	2 10	YES 2	CHO		COMPLETION OF CAUSE OF DEATH?
	been #	Σ	covonary												1	YES 2 NO
AF	S de la	AN	DID TOBACCO USÉ CONTR	RIBUTE TO CA		_		S L 1			ERTAIN					
E ST	No.	SICIAN:	EXAMINER?	HOSPITAL:				OTHER	₹:			Day 10	33.5			
A.	がいます	ξ	27. MANNER OF DEATH	28a. DATE OF	INJURY	J	28b. TIM	E OF	28c. IN	JURY AT		Other (Sp		JURY OC	CURED	
O.	marked a	BY PHY	1 Sturel 5 Pending 2 Accident Investigation	(Month, D	ay, Year)		INJ	URY M	W	YES 2] NO					
	5 < 6		3 Suicide 8 Could not be	28a. PLACE O building,	F INJURY -	At hor	ne, farm, s	treet, facto	ory, offi	ca	-	28f. LOCATIO City or To		nd Number	r or Rural Ro	ute Number,
DINISIO	DIRECTOR: hours after item 28 i	ETE	4 Homicide datarminad													
		COMPLE	29a. CERTIFIER (Check only one)													
	HOSPITAL FUNERAL WITHIN 72 TANT: If	S	2 MEDICAL EXAMINE	R: On the basis of a	camination a	end/or Ir	rveatigatio	n, in my o	pinion,	death occur	red at the ti	me, data and	placa, and	dua to th	ne cause(a) a	and manner as stated.
	불분활동	HH HH	296 SENATURE AND TIPES OF DESTROY	Anr)					29c. LICE	ENSE NUMB	BER Co (29d. DAT	E SIGNED (A	Month, Day, Year)
1	2 6 8 ₹	5	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUS	E OF DEAT	H (ITEM	27) (Type	Print) .	_	PS	5/2	-70	7		19.	2/14
/	0		R. Ricketts	MD	lle	sti	nin.	5/2	7	MI	D	211	15	>		
			31. DATE FILED (Month, Day, Year)	32. REGISTRA	R'S SIGNAT	URE		-	/	(- 17				
			DEC2 0 1994 Ju	hi Skudes	March	14										
	,													_	$\overline{}$	

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

1 - FOR STATE REGISTRAR

ITEM: 1. PER F.H. FILM g-719 1/5/95 t.t dwg

WG ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-718 12/20/94 t.t Item # 1,12,16,17,20b Film # G 718 /2-20-94 N.A. Per Funeral Home

FOR

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCIENE

1 - STATE REGISTRAR	OMIL OF MAIN	CERTIFIC			MENIAL TIGIEI REG. NO			
1. DECEDENT'S NAME (First, Middle, Last)	(C1:C)				2. DATE OF DEATH	DAY	YEAR 3. 1	IME OF DEATH
CLIFTON CHAN	EY CLIFTON	E. Chancy	CLIFIUN	R. CHANEY	DEC 0			.15P M
4. SOCIAL SECURITY NUMBER			ONTHS DAYS		7. DATE OF BIRTH (Month, Day, Year)			CE (State or Foreign
215-46-6360		46 YRS.	OH THE DATE	HOURS WIN.	(Month, Day, Year) 4-29-19	48	,	Md
9a. FACILITY NAME (If not institution, give MARYLAND GENE	· ·	9	, -	TIMORE		9c. COU	NTY OF DEATH	
RESIDENCE OF DECEDENT			DAL	TIMORE				
10a. STATE 10b. COUNT	Y	10c. CITY,	TOWN OR LOC	ATION		-	10d	. INSIDE CITY
Md		Ba	lto				10	YES 2 NO
100. STREET AND NUMBER			1	Of, ZIP CODE		10g. CIT	ZEN OF WHAT	COUNTRY?
1411 Division				21217		U	SA	
11. MARITAL STATUS 1 Never Married 2 Married	12. WAS DECEDENT EVER FORCES? 1 \(^\text{Y}\) YE	IN U.S. ARMED	13. WAS DI	CENDENT OF HISPAI	HC ORIGIN? (Specify Yon, Puarto Rican, atc.)	a or No-	14. RACE — / Black, Wh	imerican Indian, ite, etc.
3 Widowed 4 Divorced	IF YES, GIVE WAR OR	DATES		S 2 X NO Specif			Specify:	Black
15. DECEDENT'S EDU	CATION	18a. DECEDENT'S US			16b. KIND OF BI	JSINESS/INC		D T G C K
(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5 +)	(Give kind of wor life. Do NOT use i	rk done during r retired.)	nost of working				
12th		Unknow	n					
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NA	ME (First, Middle, Maide	n Surname)		
Rb E. Chan	ey Robert	Chaney		Mary E	dmonds	Mary	Edmunds	4
19e. INFORMANT'S NAME (Type/Print)					Ploute Number, City or To			7
Robert Caney			Dolfie			_	21215	
20a. METHOD OF DISPOSITION 1 () Burlai 2	noval from State 2	ob. PLACE AND DATE OF emetery crematory or othe Garrison	DISPOSITION (Vame of	121294 OW		City or Town,	
21. SIGNATURE OF FUNERAL SERVICE LI		1 00111301	22. NAME	AND ADDRESS OF FA	CILITY			
thone	H AK	mpsm	Marc	h F/H West	Avenue B	1+0	Md 21	21 5
23. PART i. Enter the diseases, or	complications that caus	ed the deeth. Do not	enter the m	ode of dving, euc	h as cardiac or resr	artory en	reet I	Approximata
immediate cause (Final	List only one cause on	each line.		,g,g		andtory or		intarval Between
disease or condition ACUTE MARCONTO TAXONTON AND CONTROL OF CHAIN AUTHORISM								
resulting in death)	DUE TO (DR AS	A CONSEQUENCE DE):	LON AND	ODSTRUCTION	OF SMALL II	1103111	IC.	
and the factor of the factor o	L DELAYED COM	PLICATION OF	POST OP	ERATIVE ADH	ESIONS			
Sequentially list conditions, if any, leading to immediate	DUE TO (OR AS	A CONSEQUENCE OF):						
CHOSE (Disease of Infinity	LONG TERM CO		F INTRA	-ABDOMINAL	ABSCESS			
that initieted eventa resulting in death) LAST	DUE TO (OH AS	A CONSEQUENCE OF):						
	d						i	
PART ii. Other significent condition	ne contributing to deeth	but not resulting in	the underlyi	ng ceuse given in		N AUTOPSY		E AUTOPSY FINDINGS LABLE PRIOR TO
					1 YES		COM	PLETION OF CAUSE DEATH?
								YES 2 NO
DID TOBACCO USE CONT	RIBUTE TO CAUSE				1 D			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	HOSPITAL:	28. PLACE OF DEATH	(Check only one)				
27. MANNER OF DEATH	1 Inpatient 2 ER/Ou	200 - 000		me 5 🗆 Residence				
1 Netural 5 Pending	(Month, Day, Year)	FOUNDUR	28C. II	IJURY AT YORK? YES 2 XX NO	28d. DESCRIBE HOW	INJURY OC	CURED	
2 Accident Investigation 3 Suicide & VV Could not be	FOUND 12-6-	94 5:00 F RY — At home, ferm, etre			28f. LOCATION (Street	and Mumber	as Charl Charle	N
4 Homicide 8 XX Could not be determined	building, etc. (Sp	FOUND AT HO			City or Town, State	1411 D	IVISION ORE, MAR	ST.
29a. CERTIFIER 1 CERTIFYING PHYS	ICIAN: To the best ot my kno	wiedge, death occurred	et the time, da	la and place, end due				TEMILD
	R: On the basis of axeminat							manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIE	A A A			29c. LICENSE NUN	IBER	29d, DAT	E SIGNED (Mon	th, Day, Yeer)
plenni	1 / Chute	D.		O.C.M.	Ε.	DI	EC. C	7/94
30. NAME AND ADDRESS OF PERSON WH	//							
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIG	11 Penn S	Stree	t, Balti	more, Ma	aryla	and 21	201
I JI. DATE FILED (MOREN, Day, 1987)	I W HEISTDAD'S SIG	MAILIRE						
DEC 2 0 1994	61: 14	· Rarlatt						

TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760,

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-18 Rev 1/89

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

Ze hours after death. Page 6 may be retained by the hospital or attending physician. filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should notified at once. be must medical examiner 0 the completely other traumatic event. executed within burial physician and Mental Hygiene prior to 50 shows any injury, signed by the a has been a item 23 DIRECTOR: After this certificate thours after death with the State liem 28 is marked, or item OR ATTENDING PHYSICIAN: FUNERAL | = TO THE HOSPITA
TO THE FUNERA
DE filed within 72
IMPORTANT: II

31. DATE FILED

32. REGISTRAR'S SIGNATURE

94 37490 b1h FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Mary Cieniawsk Dec 994 0135 8. BIRTHPLACE (State or Foreign Country) 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) August 17, DAYS HOURS 1 🗌 M 2 💢 F 212-09-4757 YRS West Virginia 78 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RECTOR 5102 Laurel Avenue N/A Baltimore 10e STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland N/Aā Baltimore City 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 5102 Laurel Avenue 21215 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—It yee, specify Cuban, Mexican, Puerto Rican, atc.)
1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indien, Black, White, atc. 1 Never Merried 2 Merried FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES BY Specify: 3 Widowed 4 Divorced White 16e. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade (Give kind of work done life. Do NOT use retired.) 12 years College (1-4 or 5+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname Joseph McDonnell Pauline Webb BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Susan Burucker 6606 Moyer Avenue Baltimore, Maryland 21206 20e. METHOD OF DISPOSITION
1X Buriel 2 Cremetion 3 Removal from State
4 Donetion 5 Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of DATE 20c. LOCATION - City or Town, State Druid Ridge Cemetery 12 - 19Pikesville, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Mitchell-Wiedefeld Home George errane 6500 York Road Baltimore, Maryland 21212 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Intarval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition reaulting in death) CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO 1 NES 2 | NO DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1X YES 2 NO 4 Nursing Home Residence 6 Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF INJURY 26d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending M 1 YES 2 NO BY Accident 26a. PLACE OF INJURY — At home, tarm, street, factory, office building, etc. (Specify) 3 Sulcide 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, end due to the cause(e) end manner as stated. 🛊 📉 MEDICAL EXAMINER: On the basic of axaminstion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) and manner ee stated. MONATURE AND TITLE OF CERTIFIER 29b. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE C.M.E 17 1994 2 Dec SS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

111 Penn Street, Baltimore, Maryland

DHMH-16 Rev 1/89

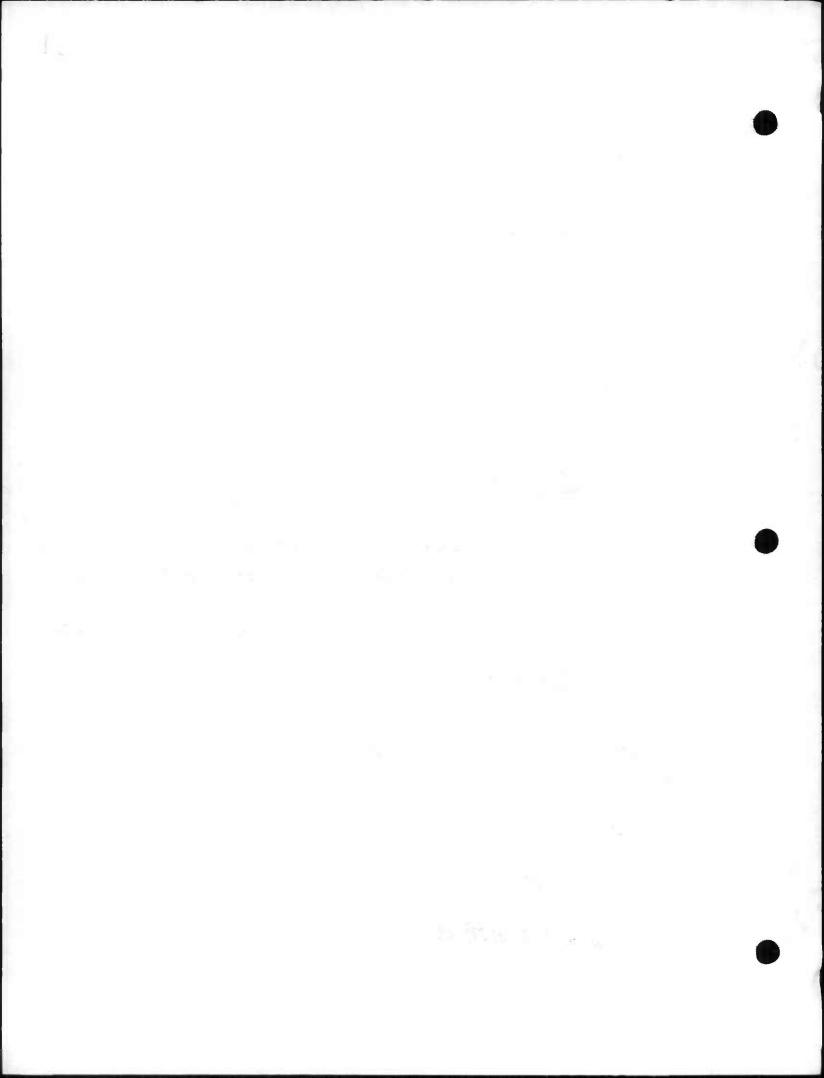
TO WE HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the property of the property of the property of the property of the property of the property filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

###PORTANT: If Hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be netfilled at once. BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

						IOAII		DEA			EG. NO.				
}	1. DECEOENT'S NAME (First, William M						2. DATE OF I MONTH Decemb	DA	4,19	YEAR	3. TIME OF OEATH	м			
	4. SOCIAL SECURITY NUMB	ER	5. SEX	8. AGE (In yrs.	last birthday)	IF UNDER	R 1 YEAR	IF UNDER	R 24 HRS.	7. DATE OF E		4,12		IPLACE (State or Foreig	10
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	218-05-81			9	1 YRS.					Februa	iry 3	_		MD	
_	9a. FACILITY NAME (If not in	stitution, give s	treet and number)			9b. CITY	Y, TOWN	OR LOCATI	ON OF OE	ATH		9c. COU	INTY OF D	EATH	
DIRECTOR	Meridian Nu	rsing	Center S	everna	Park	S	Seve	cna F	Park			Ar	ne A	rundel	
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ا لا	Alfred H.	Comegy	S					Ne	ellie	ì.	unk				
8	19e, INFORMANT'S NAME (7	ype/Print)			19b. MAILING	AOORES	S (Street)	and Numbe	r or Rural F	Route Number, C	Lity or Your	Stota 7	n Codel		$\overline{}$
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	21. SIGNATURE OF FUNERA	L SERVICE LIC	ENSEE	11				ND ADORE					- 7		
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			n H. Wil] 3	3204	Mour	ntain	Road	Pasa	idena	, MD	21122	
	23. PART I. Enter the di shock, or h	iseasea, or c eert feilure.	complications tha List only one ceu	t caused the	daath. Do i	not antar	r the mo	da of dy	ing, suci	n aa cardiac	or reapl	ratory ar	reat,	Approximete interval Betw	
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	disease or condition	-		Kes	m	A	7.L		11	2///	NI	19		2 M	A-2
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		Investigation				M	1 🗆	YES 2	□ NO						
- 10	3 Suicide 6	Could not be	28e. PLACE O	F INJURY — At etc. (Specify)	home, farm,	street, fac	tory, offic			281. LOCATIO	N (Street a	nd Numbe	or Rural I	Route Number,	
<u> </u>	4 Homicide	determined	a and any	vic. (opcony)						City or 10	wn, State)				- 1
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2 ∦	30. NAME AND AGORESS OF		O COMPLETEO CAUS	SE OF OEATH (TEM 27) (Type	Print)	_		-	1 -				. []	-
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THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within an order of the flower of the hospital or attending physician.

TO THE HANGHAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be much within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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	1 - FOR STATE REGISTRAR	STATE OF M	MARYLAND /	DEPAR ERTIF	RTMENT O	F HEAI	TH AND	MEN	ITAL HYGIEN			
	1. DECEDENT'S NAME (First, Middle, Last)								ATE OF DEATH	av.	YEAR	3. TIME OF DEATH
	Norma Vaugh							D	cember	19	1994	12:40 PM
	4. SOCIAL SECURITY NUMBER 213-05-1892	5. SEX	6. AGE (In yrs. las	6 yrs.		NTHS DAYS HOURS MIN.			ATE OF BIRTH Month, Day, Year) 1-9-190	8	Country	tace (State or Foreign
TOR	9a. FACILITY NAME (If not institution, give Union Memor		pital		96. сату, то Ва		cation of		ATH			
DIRECTOR	100. STATE 10b. COUNT	Υ		10c, CIT	Y, TOWN OR L	cation	ore					10d. INSIDE CITY LIMITS?
FUNERAL	100. STREET AND NUMBER 3650 Elm Aven	iue				10f. ZIP	212	11		10g. CIT		HAT COUNTRY?
B∀	11. MARITAL STATUS 1 Never Married 2 Merried 3 Nividowed 4 Divorced	MED	If ye		NT OF HISP Cuben, Mexi NO Spe	ican, Pus	American Indian, White, aic. white					
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5+) Secretary						vorking	Hampden United Methodist Chu				
BE CO	Charles w. Thompson											
10	198. INFORMANT'S NAME (Type/Print) Betty M. Vaughan Gold	demith (Dau	ighter)	3 6 5 0	Elm	et and Nu Ave	nue	Bal	Vumber, City or Tow timore	n, State, Zip MD	212	11
20s. METHOD OF DISPOSITION 1X) Muriei 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify)								City or Tow Ville	n, State			
	21. SIGNATURE OF FUNERAL SERVICE LI	nss Can	penter	٠	Bui	gee		SS	Funera Balti			21211
	23. PART I. Enter the dimenses, or shock, or heart failure.	complications that List only one cau	caused the de se on each line	ath. Do r	not enter the	mode o	dying, su	ich ss	cardiec or respi	ratory sn	rest,	Approximate interval Between
	IMMEDIATE CAUSE (Final disease or condition resulting in desth) a. METASTATIC OVARIAN CARCINOMA DUE TO (OR AS A CONSEQUENCE OF):										6 months	
RTIFICATION	Sequentisily list conditions, if sny, leading to immediate cause. Enter UNDERLYING											
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PHYSICIAN: MEDICAL C	PART II. Other significant condition				in the under	ying ceu	ise given i	in Part	24a. WAS AN PERFOR	MED?		VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? I YES 2 NO
AN	DID TOBACCO USE CONT 25. WAS CASE REFERRED TO MEDICAL	RIBUTE TO CA		_	S NO		NCERTA	IN []			
SIC	EXAMINER? 1 YES 2 NO	HOSPITAL:			OTHER:		Pasidana		When (Encoffed			
	27. MANNER OF DEATH 1 Natural 5 Pending Investigation	28a. DATE OF (Month, D	INJURY	26b. TIM	E OF 28c	INJURY /		7	DESCRIBE HOW II	NJURY OC	CURED	
ETED BY	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. PLACE O building,	F INJURY — At ho	me, farm, s	stree1, factory,	offica			LOCATION (Street a City or Town, State)	ind Number	or Rural Ro	ute Number,
NOW	29e. CERTIFIER (Check only one) 2	ICIAN: To the best of ER: On the basis of as										and manner as ataled,

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or in restigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. TURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day,

BENNE 994, Juli PAULA H.D. MEMORIAL UNION HOSPITAL.

ours after death. Page 6 may be retained by the hospital or attending physician BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and complete be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, crem IMPORTANT: If Hem 28 is marked, or Item 23 shows any injury, or other traumatic event

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	1 - FOR STATE REGISTRAR		STATE OF N	MARYLANO /			T OF H E OF			MENTA	L HYGIEN REG. NO	E			
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	4. SOCIAL SECURITY NUMBER	R	5. SEX	6. AGE (In yrs. las		IF UNDE	R 1 YEAR	IF UNDER	24 HRS.	7. DATE	OF BIRTH		s. BIRTHP	LACE (State or Fo	reign
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DIRECTOR	90. FACILITY NAME (# not ins Bay Meado	ws Nur		ne	Glen Burnie					EATH	ATH Anne Arunde				
EG	RESIDENCE OF DEC	10b. COUNTY	-		10c, CIT	Y. TOWN	OR LOCATI	ION						10d. INSIDE CITY	
뜬	Maryland	Anne	Arundel				Buri							LIMITS?	
	10e. STREET AND NUMBER							ZIP COD	F			I son CITI		1 YES 2XX	NO
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	15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY														
	(Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (Give kind of work done during most of working life. Do NOT use retired.)														
집	7th Grade Supervisor Van Lines														
COMPLETED		exande	-					18. MOT	HER'S NA	ME (First,	Middle, Maiden	Sumame)			
BE C															
198. INFORMANT'S NAME (TyperPrint) Mrs. Laura Virginia Clark 198. MAILING ADORESS (Street and Number or Bural Route Number, City or Town, State, Zip Code) 232 Poplar Ave., Glen Burnie, Md. 21061 208. METHOD OF DISPOSITION 200. PLACE AND DATE OF DISPOSITION (Name of OATE 200. LOCATION — City or Town, State)															
	1 X Burial 2 Cremation 4 Denation 5 Other	3 🗆 Remov	val from State	- Gien	Have	n Me	mori	al P	k. 1		Gle		-	Maryla	and
	21. SIGNATURE OF FUNERAL	SERVICE LICE	Kevi	n E. Eck	er						lome of				
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CERTIFICATION	resulting in death) LAST	d.													
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COMPLET			IAN: To the best of												
Ö	MEOIO	AL EXAMINER	On the beals of e	xamination end/or i	Investigation	on, In my	opinion, de	eth occur	red at the	time, data	and place, an	d dua to the	cause(s)	end menner se st	ated.
w l	29b. SIGNATURE AND TITLE	сентинея	Ž					29c. LICI	ENSE NUN	MBER		29d. DATE	SIGNED	Month, Pay, Year)	
0 8	NO K	Tun)	1					DY	441	21		•	(8)	13/9V	
	THE MAME AND ADDISON OF	BERROWN WHO	COMPLETED CARS	SE OF SERVICE		CD 1 11				7				11.1	_

32. REGISTRAT'S SIGNATURE

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DIVISION OF VITAL RECORDS, P.O. BOX 687604

THE EVERTAL DESCRIPTIONS PHYSICIAN: The law requires that the death certificate be executed with completely filled in by the funeral director, page 5 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.

MPOHIANT If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR		CERTIFIC	ATE OF	DEATH	VILLUIAL	REG. NO.	_		
1. DECEDENT'S NAME (First, Middle, Leat)	K. Col	Λ <i>EE</i>			2. DATE OF MONTH	DA	Ğ	94	3. TIME OF DEATH
	SEX 6. AG		UNDER 1 YEAR	IF UNDER 24 HRS, HOURS MIN.	7. DATE OF (Month, E	BIRTH Day, Year)	18	8. BIRTH	PLACE (State or Foreign
90. FACILITY NAME (If not institution, give street SING) HOSPIT	A of BA	HI more	BA	HIMO/		7	9c. COU	NTY OF DE	EATN
RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c, CITY, TO	OWN OR LOCA	TION					10d. INSIDE CITY
MAXILAND		Br	STIP	PORE					LIMITS?
10e. STREET AND NUMBER	0.4-6	1	10	1. ZIP CODE					NAT COUNTRY?
CROSS KEYS RU.	APT. E.			21210			Y	15.A	
11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WIdowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—It yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. RACE — American Indian, Black, White, etc. 15. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO Specify: WHITE									- American Indian, Whita, etc.
15. DECEDENT'S EDUCATE (Specify only highest grade con		18a. DECEDENT'S USU (Give kind of work	done during m	ON ost of working	18b, K	ND OF BUS	INESS/IND	USTRY	
Elementary/Secondary (0-12)	College (1-4 or 5+)	RETAIL	MAR	AGEMEN	T Va	SAK	ME	VT	STORE
17. FATHER'S NAME (First, Middle, Last)	OHEF			18. MOTHER'S NAI	ME (First, Mid	dle, Maiden	Surname)	,	
19a. INFORMANT'S NAME (Type/Print)	TIRR	19b. MAILING ADI	DRESS (Street	and Number or Rural F	Route Number,	City or Town	, Statu, Zip	Code)	
SOHN V. TALBER	et .	1 CROSS	KEYS	RP. AT.	E. C	PALTO	10	1, 2	1210
20e. METNOD OF DISPOSITION 1 Burlet 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	I trom State	Ob. PLACE AND DATE OF DI emetery, cremetory or other in SREEN MOUNT	SPOSITION (Notice)	ne of	12/9°	20c. LO	PATO	City or Tov	wn, State
21. SIGNATURE OF FUNERAL SERVICE LICENS			22 NAME A	ND ADDRESS OF FAC	CILITY	1500	AC0		
· William R.	lace !	7	4905	YWISENI YORK W.	GALTO	. Jeg.	21	217	
23. PART I. Enter the dieeasea, or com ahock, or heart fellure. Lief	iplicatione that caus	ed the deeth. Do not o	enter the me	ode of dying, auch	aa cardie	c or reepi	ratory arr	est,	Approximate Interval Between
IMMEDIATE CAUSE (Final disease or condition reaulting in death)	VEW	TRICULARLIS A CONSEQUENCE OF):	ARRH	41 MITY	-				Onset and Death
Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events reaulting in death) LAST		S A CONSEQUENCE OF):							
PART II. Other algnificant conditions of	ontributing to deeth	but not resulting in the	ne underlyin	g ceuse given in i		PERFOR	MED?	24b.	WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN?
					/			1	1 YES 2 7
DID TOBACCO USE CONTRIB	UTE TO CAUSE			UNCERTAIN	1 💢				
	OSPITAL:	26. PLACE OF DEATN (C	heck only one						
1 YES 2 NO 1	☐ Inpetient 2 ☐ ER/O			ne 5 Rasidence					
1 Natural 5 Pending	(Month, Day, Year		W	URY AT ORK? YES 2 NO	28d. DEŞCR	IBE NOW IN	JURY OCC	CURED	
2 Accident Investigation 3 Suicide B Could not be	28a. PLACE OF INJU	RY — At home, term, stree			28f. LOCATI	ON /Street o	ad Months	ns 0	
4 Nomicide 8 Could not be	building, atc. (S)	pecify)	i, tactory, orni			fown, State)	nu number	or nursi no	oute Number,
29a. CERTIFIER (Check only	N: To the best of my kno	owledge, death occurred at	the time, date	end place, end due	to the ceusei	(a) and man	ner ee stet	ed .	
one) 2 MEDICAL EXAMINER: O									end menner as stated.
296. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUM					(Month, Day, Year)
- LUS	Yum			D 2 92	20		•	2/16	194
30. NAME AND ADDRESS OF PERSON WHO CO			*	1100	0			1.41	- 1
TROOB S	UNUESS , N		SINA	HOSP OF	BALT				
"DE CZ" 0 1994" Julia	PORTUGUE POR	ATTRE							



A. Brands January

DIVISION OF VITAL RECORDS, P.O. BOX 68760

PHECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 may be retained by the hospital or attending physician.

The Director page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. SPINE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR

	1 - STATE REGISTRAR		CERTIF	ICATE OF	DEAT	H	REG. NO.	_		
	1. DECEDENT'S NAME (First, Middle, Last)						OATE OF DEATH			TIME OF DEATH
	JAMES BER	NARD	CA	RTER		D	ECEMBER	(16,	1994	M
	4. SOCIAL SECURITY NUMBER 5. S	SEX 8. AGE (In yrs	last birthday)	IF UNDER 1 YEAR	IF UNDER		DATE OF BIRTH	I	8. BIRTHPL	ACE (State or Foreign
	218.18.0724 1X	M 2 □ F	YRS.	MONTHS DAYS	HOURS	MIN. A	PRIL 8	1922	MAR	YLAND
	9a. FACILITY NAME (If not institution, give street a	and number)		9b. CITY, TOWN	OR LOCATIO	N OF DEATN		9c. COUN	ITY OF DEAT	н
DIRECTOR	898 TIMBER RIDG	E DRIVE		НА	NOVE	R				RUNDEL
2	RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY		Inc. CIT	Y, TOWN OR LOCA	TION					
IH	MARYLAND ANNE A	PHADEL		ANOVER	IIION			10d. INSIDE (LIMITS?		
	10e. STREET AND NUMBER	TRONDER			r. ZIP CODE				-	YES 2 NO
FUNERAL	898 TIMBER RIDG	E DRIVE			2107			U.S.A		
5	11. MARITAL STATUS 1 Never Married 2 Married	WAS DECEDENT EVER IN U.S. FORCES? 1 X YES 2	ARMED				RIGIN? (Specify Yes	or No-	14. RACE -	American Indian,
ВУ		IF YES, GIVE WAR OR OATES 1942-1948			If yes, specify Cuben, Mexican, Puarto Rican, etc.) 1 TYES 2 TXNO Specify: Specify: Specify: BL					BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) 12 12 13. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondary (0-12) 12 13. LANDSCAPING - PAVING LANDSCAPING - 15. MOTHER'S NAME (First, Middle, Last) 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LANDSCAPING - 16. MOTHER'S NAME (First, Middle, Meiden Surname)								USTRY		
12 LANDSCAPING - PAVING LANDSCAPING - PAV									- PAVING	
17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname)										
SAMUEL A. CARTER NORA E. KELLY										
	19a. INFORMANT'S NAME (Type/Print)	732-8-5-5-5	19b. MAILING	AOORESS (Street	and Number	or Rural Route	Number, City or Town			
20s. METHOD OF DISPOSITION 1 Surial 2 Cremetton 3 Removal from Stale Complex, complex or other place. 20b. PLACE AND DATE OF DISPOSITION (Name of complex), complex or other place.									21076	
	21. SIGNATURE OF FUNERAL SERVICE LIGHTISEE 22. NAME AND ADDRESS OF FACILITY									E, MD.
		A	1				SINGLE			ERAL HOME
_	and.	Det	200							NIE, MD.
	23. PART I. Enter the diseases, or comp shack, or heart failure. List of	lications that caused the	death. Do n	ot enter the m	ode of dyin	ng, such as	cerdiac or reepi	ratory arm	est,	Approximata Interval Batween
	IMMEDIATE CAUSE (Finel	10,0	1.		1	/	0	- 24		Onset and Daeth
	disease of condition e.	4 cule 1		cooke	F.	reg	mer cu	P)		
	1/2	OUE TO (OR AS A CON	SEQUENCE OF	1 8- 8	0	1	00.001			
NO	Sequentially list conditions,	120700	Duy	D COSOL	of	12	yora	20)		
CERTIFICATION	if any, leading to immediate cause. Enter UNDERLYING	OUE TO (OR AS A CON	SEGUENCEYO	16000		1-2	Eubert	2		
FIC	CAUSE (Disease or Injury	DUE TO (OR AS A CON	SECUENCE OF	0.						
Ē	thet initiated eventa reaulting in death) LAST		OLOULAIDE OF	<i>y</i> -						į
E										
	PART II. Other significant conditione cor	ntributing to death but-ne	et resulting i	n tha underlyin	g ceuse g	iven in Per	i. 24a. WAS AN			RE AUTOPSY FINDINGS
DICAL	() Nobelen	reculu)				1 TYES 2	4	co	AILABLE PRIOR TO MPLETION OF CAUSE
						_			1	DEATH? YES 2 NO
2	DID TOBACCO USE CONTRIBU	ITE TO CAUSE OF D	EATH YE	S I NO É	UNC	ERTAIN [¬ l			
PHYSICIAN: ME	25. WAS CASE REFERRED TO MEDICAL	28. P		N (Check only one						
Sign	1 7 1/22 2 7/112	SPITAL: Inpatient 2 - ER/Outpatient	3 DOA	OTHER: 4 Nursing Hor	10 5 G.B.	ndence 8 🗆	Other (Specify)			
ξl	27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIMI		IURY AT		I. OESCRIBE HOW I	JURY OCC	UREO	
ВУ	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Your)	1113		YES 2	NO				
	3 Suicide 8 Could not be	28a. PLACE OF INJURY — Al building, etc. (Specify)	home, lerm, s	treet, lectory, offic	·a	281	LOCATION (Street a City or Town, State)	nd Number	or Rural Route	Number,
<u> </u>	4 Nomicide determined	January, etc. (opcory)					City or lown, State)			
7	29e. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.									
BE DOMPLETED	one) 2 MEDICAL EXAMINER: On									d manner as stated.
9	29% SIGNATURE AND TITLE OF CERTIFIER	Alt .	1	_	29c. LICE	NSE NUMBER		29d, DATE	SIGNED (Mc	onth, Day, Year)
7	Mynay	Mending	000	los	1	216	84	•	12.	16.54
F	30. NAME AND ADDRESS OF PERSON WHO COM	MPLETED CAUSE OF DEATH (TEM 27) (Type,	Print)	- 106	Go	RNBY	RNU	210	6.12
- 1	- - -	1000		~11.				الم	X (D	6/
	31. ONTEFILED MONTH PORTON	PARESTURANT CONTROL	Ē							

0.00

FOR 5 STATE REGISTRAR	STATE OF MARYLAND /	. T. Departmi Ertific <i>a</i>				ENTAL HYGIEN			
1. DECEDENT'S NAME (First, Middle, Last)					:	2. DATE OF DEATH		3. TIME OF DEATH	
SOHN C	SBY JOHN	COSBY				DEC 16	6:20 AM		
4. SOCIAL SECURITY NUMBER 5 1 2 3 7 14-9296 1	6. AGE (In yrs. les	YRS, WONT	NDER 1 YEAR THS DAYS	IF UNDER 24 HOURS	HRS. 7	7. DATE OF BIRTH (Month, Day, Year)		HRTHPLACE (State or Foreign	
9a. FACILITY NAME (If not institution, give street	end number)	96.	CITY, TOWN O	R LOCATION	OF OEAT	TH	9c. COUNTY	OF DEATH	
SINAI HOSPI	TAL			IMD	RE	MD	BALT	IMDRE	
10a. STATE 10b. COUNTY		10c. CITY: 101	THI	MOR	e			10d. INSIDE CITY LIMITS? 1 VES 2 NO	
2946 W. Non	th ave		101.	ZIP CODE	15	-	10g. CITIZEN	OF WHAT COUNTRY?	
11. MARITAL STATUS 1 Mas DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE - American India Black, Whita, atc. 1 YES 2 NO NO 14. RACE - American India Black, Whita, atc. 1 YES 2 NO NO NO NO NO NO NO									
15. OECEDENT'S EDUCATION (Specify only highest grade completed) [Give kind of work done during most of working life. Do NOT use relified.) [RADUCITE L. 2472. [Seementary(Secondary (0-12) 2472. [Seementary(Seementary (0-12)									
17. FATHER'S NAME (First, Middle, Last) Amer Cosby	/			18. MOTHER	CILLLE	E (First, Middle, Meiden	Surname)		
190. INFORMANT'S NAME (TOPOPPINT)	3	30/ E	RESS (Street at	/	Rural Rou	BAHO,	n, State, Zip Code	2/2/6	
20b. PLACE AND DATE OF DISPOSITION Turlet 2 Cremation 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name of camelary, Cremation 5 Other (Specify) DATE 20c. LOCATION - City or Town, State camelary, Cremation 5 Other (Specify) DATE 20c. LOCATION - City or Town, State 20c. LO									
21 SIGNATURE OF FUNERAL SERVICE LICENSEE 22, NAME AND ADDRESS OF FACILITY Wallace Flague Source									
m. Callace 3405 W. Franklin St. BAHd, mel 2/229 21 PART Enter the diseases, pr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate									
shock, or heart failure. Lis	mplications that caused the de st only one cause on each line	ath. Do not e	nter the mod	de of dying	, such e	es cerdiec or respi	ratory srrest,	Approximats intervel Between	
IMMEDIATE CAUSE (Finel disease or condition resulting in death)	A NOXIC		FPHAL	OPA	TH	4		Onaet and Death	
_	DOL TO (ON AS A CONSE	DUENCE OF):							
Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING	DUE TO (OR AS A CONSEC	OUENCE OF):							
CAUSE (Disease or Injury that initiated events resulting in desth) LAST	DUE TO (OR AS A CONSEC	DUENCE DF):							
PART ii. Other algnificant conditions of	contributing to death but not -	possibles is the							
MULTIPLE MYS DIAGETES MEL	FLAMA & IN.	SULIN RTEN	DER			DEDECO	MED?	24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
DID TOBACCO USE CONTRIE				LINICEE	TAIL.	_		1 NES 2 NO	
25. WAS CASE REFERRED TO MEDICAL			NO Beck only one)	UNCER	CIAIN				
CVALUEDO	EXAMINER? HOSPITAL: OTHER:								
27. MANNER OF DEATH	27. MANNER OF DEATH 26s. DATE OF INJURY 26b. TIME OF 26c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED								
1 Natural 5 Pending Investigation	(Month, Day, Year)	INJURY	M 1 Y	RK? ES 2 N					
2 Accident Investigation 3 Suicide 8 Could not be detarmined	28s. PLACE OF INJURY — At ho building, etc. (Specify)	me, term, street,			_	261, LOCATION (Street a City or Town, State)	and Number or Ru	ural Route Number,	
	N: To the best of my knowledge, de							100(a) and an array of	
29b. SIGNATURE AND TITLE OF CERTIFIER	and the state of t		, opnison, de						
	29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Morth, Day, Year) 520486540 DEC 16, 1994								

BALTIMORE, MARYLAND 21215-0020 DIVISION OF VITAL RECORDS, P.O. BOX 68760, TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN; MEDICAL CERTIFICATION

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°1994

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EPH 22. REGISTRAR'S SHORTURE

rurs after death. Page 6 may be retained by the hospital or attending physician.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

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HOSPITAL

SINAL

		nif. Pages 1, 2, 3 should
0200	physician.	burial-transit perr
BALTIMORE, MARYLAND 21215-0020	ours after death. Page 6 may be retained by the hospital or attending physician	pletely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should
MARY	retained by	5 should b
IMORE,	Page 6 may be	director, page
BALT	ours after death.	f in by the funeral
0,0	within	pletefy filled in by the

FOR

BALTIMORE, MARYLAND	r death. Page 6 may be retained by the hosp	ne funeral director, page 5 should be detache al.	examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68760,	TO THE HIGH OW AT MOTING PHYSICIAN: The law requires that the death certificate be executed within Jours after death. Page 6 may be retained by the host	TO THE MEDITE CONTINUE AND FORTING CENTRICATE has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be not within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
AR	CERTIFICATE OF DEATH	REG NO

	1 - STATE REGISTRAR	ERTIF	ICATE OF	DEATH	MENTAL	REG. NO				
	1. DECEDINT'S NAME (First, Middle, Last)	\				F DEATH		3, 1	IME OF DEATN	
	ADA COLEMAN)			MONTH	P	* <	YEAR /	06 PM	
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. I	ast birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	7. DATE C	F BIRTN		8. BIRTHPLAC	CE (State or Foreign	
	220-12-7710 1 1 M 2 🖫 F 98	YRS.	MONTHS DAYS	HOURS MIN.	SEPT	Day, Year) . 29,	1896	LITHU		
NC.	9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN C	R LOCATION OF		. 251	_	TY OF DEATH		
	LEVINDALE						Ju. 00010	TO DEATH		
6	RESIDENCE OF DECEDENT									
DIRECTOR	10a, STATE 10b, COUNTY	10c. C/1	Y, TOWN OR LOCAT	ION				10d	INSIDE CITY	
	MARYLAND		BALTIMORE						YES 2 NO	
¥	10e. STREET AND NUMBER		101. ZIP CODE			10g. CITIZEN			COUNTRY?	
E I	2434 W. BELVEDERE AVE.		21215			5 US				
FUNERAL	11. MARITAL STATUS 1 Naver Merried 2 Merried FORCES? 1 YES 2 5	ARMED	13. WAS DEC	ENDENT OF HISE	ANIC ORIGIN	(Specify Yes	or No —		merican Indian, ite, etc.	
BY	1 Naver Merried 2 Merried FORCES? 1 YES 2 S	QNO		2 XNO Spe		can, atc.)	- 1	Specify:		
									WHITE	
国	(Specify only highest grade completed)	Give kind of	WORK done during mo	ON st of working	16b.	KIND OF BU	SINESS/IND	USTRY		
3	Conege (1-4 or 5 +)	fe. Do NOT u								
COMPLETED	17. FATNER'S NAME (First, Middle, Lest)	SE	EAMSTRESS					CLOTH	IING	
				16. MOTHER'S			Sumeme)			
BE	MEYER COLEMAN 190. INFORMANT'S NAME (Type/Print)				MANDE					
2	MRS. CHARLOTTE LAKEN	360]	ADDRESS (Street of CLARKS	LANE, AI	PT. 51	BAL'	n, State, Zip L'IMORI	Code) E MD	21215	
	20st METHOD OF DISPOSITION 20th PLACE		OF DISPOSITION (Na			_				
	4 Thurst a Daniel and a second	remetory or o	ther place)		DATE			City or Town, S		
	21. SIGNATURE OF FUNERAL SERVICE LICENSEE	MOGAL	J ABRAHAN	D ADDRESS OF	15-94 FACILITY	I R	OSEDA.	LE, MD		
	Januar & Stillman		SOL	LEVINSO	ON & B	ROS.,	INC.			
			6010	REIST	ERSTOW	N ROAL	D BAL	TIMORE	MD 2121	
	PART I. Enter the diseases, or complications that caused the canonic shock, or neert failure. List only one cause on each lin	deeth. Do i ne.	not enter the mo	de of dying, s	uch es cerdi	ec or resp	iratory arre	est,	Approximata intervai Between	
	IMMEDIATE CAUSE (Fine) Onset and Death									
	disease or condition e. ASC VD									
	DUE TO (OR AS A CONS	DUE TO (OR AS A CONSEQUENCE OF):								
CERTIFICATION	Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF):									
AT	if any, leading to immediate cause. Enter UNDERLYING	Lavenor o	. ,.					Ì		
띮	CAUSE (Disease or injury that initieted events DUE TO (OR AS A CONSI	EOUENCE O	F):							
F	resulting in deeth) LAST							1		
DICAL	PART II. Other significent conditions contributing to death but not	resulting	In the underlying	ceuse given	in Part I.	24a. WAS AN PERFOR			E AUTOPSY FINDINGS LABLE PRIOR TO	
ă						1 TYES 2	□ NO	COM	PLETION OF CAUSE DEATH?	
ME								1 🗆	YES 2 NO	
PHYSICIAN:										
5	25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL:		28. PL	ACE OF DEATH	Check only one					
YS	1 YES 2 NO 1 Inpetiant 2 ER/Outpetiant	3 🗆 DOA	4 Nursing Hom	n 5 🗆 Residenc	a 8 🗆 Othar	(Specify)				
표	27. MANNER OF DEATN 1	28b. TIM		URY AT RK?	28d. DE\$0	RIBE HOW I	NJURY OCC	URED		
BY	2 Accident Investigation			ES 2 NO						
	3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At 1 building, etc. (Specify)	nome, term,	street, factory, office		28f. LOCA City o	TON (Street in Town, State)	and Number	or Rural Route	Number,	
E										
릴	29a. CERTIFIER (Check only 1 CERTIFYING PNYSICIAN: To the best of my knowledge, of									
ō l	one) 2 MEDICAL EXAMINER: On the basic of examination and/o	r investigatio	on, In my opinion, d	eth occured at t	he time, data a	nd place, an	d dua to the	cause(s) end	menner as stated.	
BETCOMPLETED	296. SIGNATURE AND TUTE OF CERTIFIER			29c. LICENSE N	UMBER		29d. DATE	SIGNED (Mon	th, Bay, Year)	
	My Clace M.	0		043	473		> /	2/13	196	
일	30. NAME AND ADDRESS OF PERSON WHO SOMPLETED CAUSE OF DEATH (IT	EM 27) (Type	, Print)		1/0			1,-1		
	Cenadale benatic Ce	Aen	1	4/1/A	rano-		41			
	31. DATE FILED (Month, Day, Year) DEC2 0 1994 July 22. REGISTRAR'S SIGNATURE			- 1111						
1	UEC2 0 1994 Julia Maria									

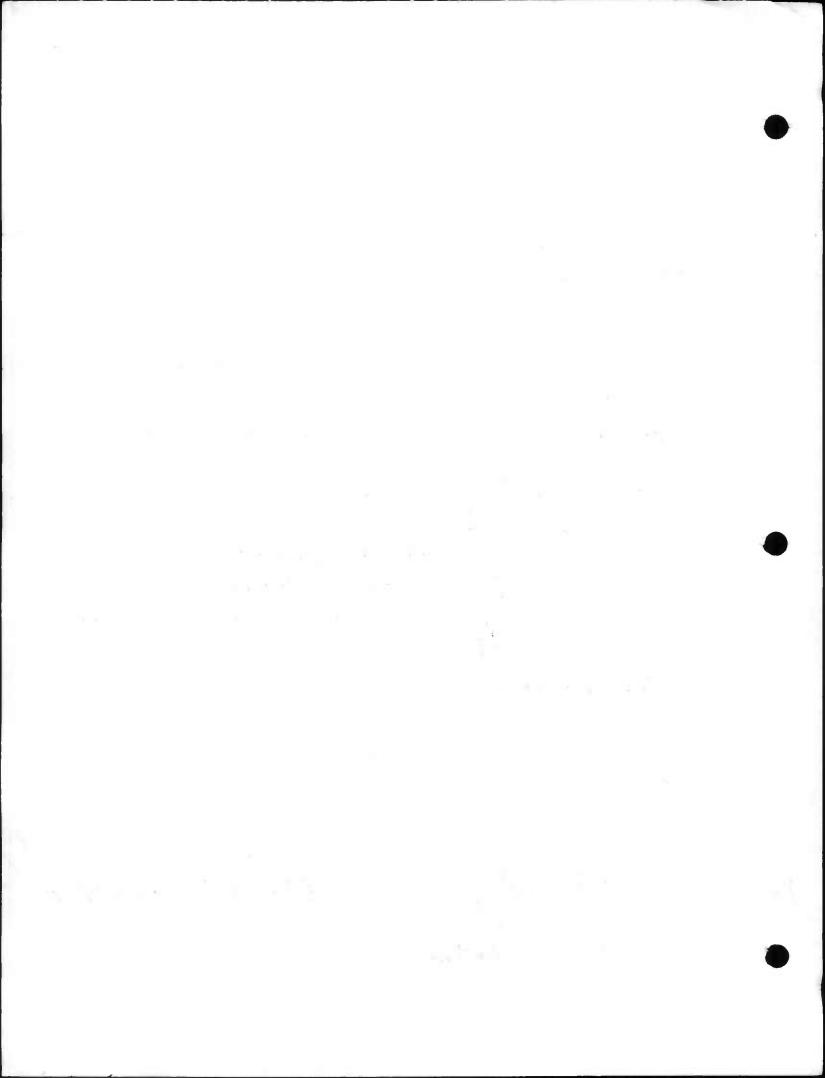
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TO THE HOSPITAL DR ATTENDING PROGRAM THE PROPERTY THE PROPERTY OF THE PROPERTY OF THE PROPERTY PROPERTY OF THE	TOR: A per this permission has been sugned by the amending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit	after de the man that the contract with Myglene prior to burial, cremation, or removal.	MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once
ATTEN	ECTOR	rs after	n 28
AL DR	IL DIRI	2 hour	f item
OSPITA	JNERA	ithin 72	NAT: H
工器工	TO THE FUNERAL DIRECTO	be filed within 72 hours after de	PORTA
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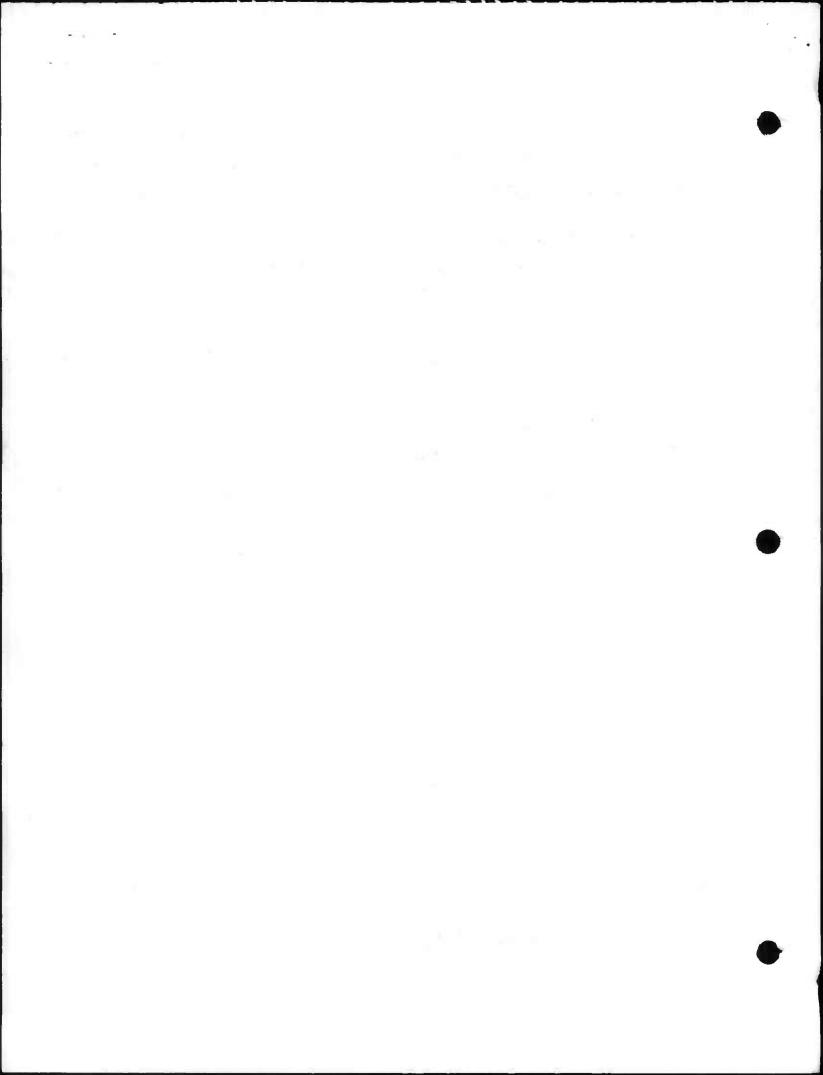
	1 - FOR STATE REGISTRAR	STATE OF MARYL		RTMENT OF I		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATN		3. TIME OF DEATN
1 3	EMAGENE P. DO	LLENBERG					7/1994	
1 4	4. SOCIAL SECURITY NUMBER		(In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. B	IRTNPLACE (State or Foreign puntry)
	219-34-4599	1 M 2 T F 89	YRS.	MONTHS DAYS	HOURS MIN.		905	Arkansas
-	9e. FACILITY NAME (If not institution, give si	treet and number)		9b. CITY, TOWN	OR LOCATION OF	DEATN	9c. COUNTY C	OF DEATH
DIRECTOR	Pickersgill Home			Towso	n		Balt	imore
E	10e. STATE 10b. COUNTY	,	10c. Cr	TY, TOWN OR LOCAL	TION			10d. INSIDE CITY
뜸	Md. Balt	imore	474	Towso				LIMITS?
4	10e. STREET AND NUMBER				1. ZIP CODE		10a, CITIZEN O	OF WHAT COUNTRY?
ER/	609 W. Joppa Rd.				21204			S.A.
FUNERAL	11. MARITAL STATUS	12. WAS DECEDENT EVER I		13. WAS DEC	CENDENT OF NISP	ANIC ORIGIN? (Specify Ye	s or No.— 14, R	IACE — American Indian,
BY F	1 Never Married 2 X Merried 3 Widowed 4 Divorced	FORCES? 1 TYES IF YES, GIVE WAR OR D			ecify Cuben, Maxi-	can, Puarto Rican, etc.)		Black, White, atc.
								White
H	15. DECEDENT'S EDUC (Specify only highest grade	completed)		Work done during me		16b. KIND OF BU	SINESS/INDUSTR	Υ.
P	Elementary/Secondary (0-12)	College (t-4 or 5+)				O 11-		
COMPLETED	17. FATNER'S NAME (First, Middle, Last)		Home Ma	aker	18 MOTHER'S N	OWN HO		
О	James R. Porter				Nell	Holden	Surnamej	
0	19a. INFORMANT'S NAME (Type/Print)		19b. MAILING	ADDRESS (Street)		I Route Number, City or Tow	yn, State, Zip Code)
일	Marilyn Gabor		- 1			timore, Md		
	20a. METHOO OF DISPOSITION 1-X Burial 2 □ Cremation 3 □ Ramo		PLACE AND DATE	OF DISPOSITION (No			CATION — City o	
3	4 Donation 5 Other (Specify)	Bı	cookvill	e Cemete:	ry 12	2/20/94 Bro	okville	, Md.
	21. SIGNATURE OF FUNERAL SERVICE LIC	заена		22. NAME AI	ND ADDRESS OF	ACILITY		
	· CUI	ナーメ				Tuneral Hom		4
	23. PART I. Enter the diseases or o	omplications that cause	the deeth. Do	not enter the mo	de of dylng, su	Towson, M	Iratory arrest,	Approximata
	IMMEDIATE CAUSE (Finel	List only one ceuse on e	ach line.					Interval Batween Onset and Death
	disease or condition resulting in death)	aspi	IA+1	on i	Mer	monik	1	27111 (325 - 1331)
		DUE TO (ON AS A	CONSEQUENCE P	8 11		1		
S	Sequentially list conditions,	. PSE	NGO !	SHILBAY	TA	154		
CERTIFICATION	if eny, leading to immediate cause. Enter UNDERLYING	DOE TO (OR AS A	CONSEQUENCE O	1000	coloca	vAscid,	ma An	vid austo
윤	CAUSE (Disease or Injury that initiated events	OUE TO (OR AS A	CONSEQUENCE O		1000	VINCOCI	77 //	Claevys
E	resulting in death) LAST	. Hv	per	rens	ion			
2	PART II Other elgolficent condition							
S S	PART II. Other significant conditions	ting to death b	ut not resulting	in the underlying	g ceuse given i	n Part I. 24a. WAS AN PERFOI		24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO
MEDIC		(1674				1 🗆 YES 2	□ NO	OF DEATH?
Σ								1 YES 2 NO
AN:	-25. WAS CASE REFERRED TO MEDICAL			24 84	ACE OF DEATH (C			
2	EXAMINER?	HOSPITAL:	etlant 3 🗆 DOA	OTHER:				
PHYSIC	27. MANNEB OF DEATH	26a. DATE OF INJURY	28b. TIN			8 Other (Specify) 28d. DESCRIBE NOW I	NILIBY OCCUBE	
BY	. 1 Netural 5 Pending	(Month, Day, Year)	IN.	JURY WO	PRK7			
	3 Suicide 6 Could not be	28e. PLACE OF INJURY building, etc. (Spec	At home, farm,	street, factory, offic	•	28f. LOCATION (Street	and Number or Rui	ral Route Number,
=	4 Homicide determined	Sunarry, etc. (c).cc.				City or Town, State)		
COMPLETED	29e. CERTIFIER (Check only	CIAN: To the best of my know	ledge, death occurr	ed at the time, date	and place, and du	e to the cause(s) and ma	nner as stated.	
o V		3: On the basis of examination						se(s) and menner as stated.
BE C	29b. SIGNATURE AND TITLE OF CENTIFIER	1 8			20g LICENSE NI	MBER 7	29d. DATE SIGN	NED (Month, Day, Year)
TO B	LIMY	heley			100	5205	12	20/94
F	30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF DE	ATH (ITEM 27) (Type	, Print)				
	A. DAYS SH SD 32							
ļ	DEC2 0 1994	32. REGISTRAR'S SIGN	Sell.					



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9	to the death cartificate he merested within
ORDS, P.O. BOX 68760,	what the density considered to recently adding the same above density from the constant to the transfer of

be retained by the hospital or attending physician. DIVISION OF VITAL RECO
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires 1
TO THE HUBBITAL DIRECTOR: After this certificate has been signs

				94	3/499			
		1 - STATE STATE OF MARYLAND / DEPARTMENT OF HI	EALTH AND MENTA	L HYGIENE				
Г		REGISTRAR CERTIFICATE OF 1. DECEDENT'S NAME (First, Middle, Last)		REG. NO.				
		ROBERT WAYNE DREYER	MON	C.17,1994	3. TIME OF DEATH			
		4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR	IF UNDER 24 HRS. 7. DATE	OF BIRTH 8.	13:45 P M BIRTHPLACE (State or Foreign			
		92. FACILITY NAME (If not institution, give street and number) 9 FACILITY NAME (If not institution, give street and number) 9 FACILITY NAME (If not institution, give street and number)	HOURS MIN. (Mon	T. 2 1958 M	PARYLAND			
	TOR	FORST HILL RECREATION AL PARK FORST	- HILL	9c. COUNTY HAR	FORD			
	DIRECTOR	106. STATE 106. COUNTY 106. CITY, TOWN OR LOCATE ABING.	DOA		10d. INSIDE CITY LIMITS? 1 YES 2 NO			
	FUNERAL		ZIP CODE	10g. CITIZEN	OF WHAT COUNTRY?			
	N N	11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECE	ENDENT OF HISPANIC ORIGI	N? (Specify Yes or No.— 14.	RACE — American Indian,			
	BY		cify Cuben, Mexicen, Puerto		Black, While, etc. Specify:			
1	COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12) College (1-4 or 5 +)	N 16 If of working	b. KIND OF BUSINESS/INDUS	TRY			
once.	M	17. FATHER'S NAME (First, Middle, Last)		IZAMEITTER.	1 rocor#138			
동	BE CC	JOHN E. DRIYIR JR	18. MOTHER'S NAME (First,	ARIE AND	RSON			
be notified	5	196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Short Street and Short Street and Short	H AVE. S	YKSSVILLS , (MARYLANO			
must		20b. METHOD OF DISPOSITION Burlet 2 Cremetion 3 Removal from State 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DISPOSITION (Name and Property) 20b. PLACE AND DATE OF DAT		20c. LOCATION - CHY	or Town, State			
examiner		NAV3	FUNIRAL CH	APEL - BELAI	RIPA. 21000			
medical	\dashv	23. PART I. Enter the diseases, or complications that coused the deeth. Do not enter the mod	PORI URIV	rdiec or respiratory arrest	Approximata			
the		shock, or heart failura. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death)			Intarval Between			
event,		DUE TO (OR AS A CONSEQUENCE OF):						
or other traumatic	CERTIFICATION	Sequentielly liet conditions, if any, leading to immediata DUE TO (OR AS A CONSEQUENCE OF):						
ther tr	FIC	CAUSE (Disease or Injury that Initiated events Due TO (OR AS A CONSEQUENCE OF):						
ny, or o	ËET	reaulting In deeth) LAST						
	- II	PART II. Other significent conditions contributing to death but not resulting in the underlying	ceuse given in Part I.	24e. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO			
shows any inju	MEDICAL			1 YES 2 NO	COMPLETION OF CAUSE OF DEATH?			
Show		DID TODACCO USE CONTRIBUTE TO ANNO OF THE TOTAL	_	, , , , , , , , , , , , , , , , , , ,	NES 2 NO			
23	PHYSICIAN:	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one)	UNCERTAIN					
item 23 shows any injury, o	띯	EXAMINER? HOSPITAL: OTHER:	5 - D - D - D - D - D - D - D - D - D -					
d, 0r	Ě	27. MANNER OF DEATH 28g. DATE OF, INJURY 28b. TIME OF 28c. INJU	5 Residence 8 XOth	SCRIBE HOW INJURY OCCUR	ED			
-36	ВУ	1 Netural 5 Pending FOMORORY (Var.) INJURY WOR 2 Accident Investigation 12-17-94 1276M 1 YE		bject burn	t in auts			
	ED	3 Suicide e Could not be 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify)	281, LOC City	CATION (Street and Number or F or Town, State)	Rural Route Number,			
Item 28	PLETE	sarking bor	ROU	/ / / . /	arch Rt 24			
11 11	E P	29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date a			ouse(s) end menner es stated.			
\$	Щ.	29b. SIGNATURE AND TITLE OF GENTINER	29c. LICENSE NUMBER	29d. DATE SI	GNED (Month, Day, Yeer)			
\$	5	E WL	OCME	DE(C.18,1994			
- 1	eri II	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)						
		1 1 C C	ceet. Ral+	imore Mar	wland 21201			
		Dand R Fowler 111 Penn Str 31. DATE FILED (Month, Day, New) DEC 2 V 1994 July Drugies Reveal.	reet, Balt	imore, Mar	yland 21201			



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		REGISTRAR	C	ERTIFICATE (OF DEATH	F	EG. NO.	
		1. DECEDENT'S NAME (First, Middle, Last)	HA DOWL	NG		2. DATE OF		EAR 3. TIME OF DEATH
		4. SOCIAL SECURITY NUMBER	5. SEX 6. AGE (In yrs. Is	st birthday) IF UNDER 1 Y	AR IF UNDER 24 HRS.	7. DATE OF I	BIRTH 8.	BIRTHPLACE (State or Foreign Country)
should	1	90. FACILITY NAME (If not institution, give si	1 M 2 WF	YRS.	WN OR LOCATION OF D	JAN.	15, 1913 7	KAFFURD PA.
1, 2, 3 sh	СТОЯ	FRANKLIN SE	PHARE HOSP.	Ro	SEDALE		Br	ATIMORE CO
Pages	DIREC	10a. STATE 10b. COUNTY MALYLAND BAL	TIMORE CO.	10c. CITY, TOWN OR L	OCATION HALL			10d. INSIDE CITY LIMITS? 1 YES 2 NO
nsit permit.	FUNERAL	100. STREET AND NUMBER 4223 PENN	AVE	1,6/4/	101. ZIP CODE	3.6	10g. CITIZE	N OF WHAT COUNTRY?
-0020 ing physician. the burial-transit	BY FUN	11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. AI FORCES? 1 YES 2 FIF YES, GIVE WAR OR DATES	NO If ye	DECENDENT OF HISPA e, specify Cubar, Mexico YES 2 NO Specifi	NIC ORIGIN? (S en, Puerto Rice	pecify Yee or No.— 14 1, atc.)	. RACE — American Indian, Black, White, etc. Specify:
215-0 attending ise as the	ED B	15. DECEDENT'S EDUC		ECEDENT'S USUAL OCCU	PATION	16b. KIN	D OF BUSINESS/INDUS	VHITE
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det the	COMPL	17. FATNER'S NAME (First, Middle, Last)	PINIO		18. MOTHER'S NA	ME (First, Middle	e, Maiden Surneme)	
MARYI retained by 5 should be notified at	BE (190. INFORMANT'S NAME (Type/Print)	1140	b. MAILING ADDRESS (St	reet and Number or Rural	Route Number 0	ELTI	70
- 2 8 e	2	HOWARD F.	DOWLING	4223	PENN	AVE.	BALTE	7,100,2123
ie 6 m rector,		20e_METNOD OF DISPOSITION 1	oval from State Cometers of	AND DATE OF DISPOSITION OF THE PROPERTY OF THE	N (Name of EY MEM	DATE 122	COCKEY	OF TOWN, State
death. Page tuneral direction		21. SIGNATURE OF FUNERAL SERVICE LIC	Pain HC	1677 22. NAM	E AND ADDRESS OF M	WES	AL CH	AL VVIIIE
hours after ad in by the or removal.		23. PARCI. Enter the discusses, or of shock, or heart failure.	omplications that ceused the di	eath. Do not antar the	moda of dying, suc	th as cardiac	or reepiratory arree	Approximate interval Batween
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ted within completely ial. crema: event,		Tooling in deatily	DUE TO JON AS A CONSE	QUENCE OF):	7		Lucio	
be executed con to burial.	ERTIFICATION	Sequantially list conditions, if any, leading to immediate	DUE TO (V) AS A CONSE	QUENCE OF):	your	ulo?	our	
certificate the ding physicilygiene prior other tra	FICA	cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSE	OUENCE OF):				
그 유 등 급 증기	ERT	resulting in death) LAST	ı					
= 4 5 <u>=</u>	AL C	PART ii. Other significant condition	s contributing to death but not	resulting in the under	lying causa givan in	Part i. 24s	. WAS AN AUTOPSY	24b. WERE AUTOPSY FINDINGS
saffth eafth	EDICAL					1 [YES 2 NO	AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
w requirements of H	Σ	DID TOBACCO USE CONTR	RIBUTE TO CAUSE OF DEA	ATH YES I NO	UNCERTAI	N DO		1 TES 2 NO
N: The law ficate has be State Dept.	SICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	28. PLA	CE OF DEATN (Check only				
SICIAN: The certificate to the State	PHYSI	1 YES 2 NO 27. MANNER OF DEATH	1 ☐ Inpatient 2 AED/Outpatient :		Nome 5 Residence			145
DING PHYS After this of death with s marked,	BY PI	1 Netural 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	INJURY AT WORK?	28d. DESCRII	BE HOW INJURY OCCUR	EO
TTENDII TTOR: A after de 28 is	ETED E	3 Suicide 8 Could not be 4 Homicide determined	28e. PLACE OF INJURY — At he building, etc. (Specify)	oma, farm, street, fectory,	office	281. LOCATIO City or To	N (Street end Number or wn, State)	Rural Route Number,
14 72 74 14 14 14 14 14 14 14 14 14 14 14 14 14	COMPLE		CIAN: To the best of my knowledge, do					ause(e) and menner as stated.
THE HOSPI THE FUNER Med within PORTANT:	BE C	296. SIGNATURE AND TITLE OF CENTIFIER	Da OM		29c. LICENSE NUI			GNED (Menth, Day, Year)
222	19	30. NAME AND ADDRESS OF PERSON WHO	COMPLETED CAUSE OF DEATH (ITE	M 27) (Type, Print)	1/34	650	12	12044
(4	:]	DR. Jeffrey Cool	9712 Be		Balto. N	10.21	236	
1	1	DEC 20 1994 Ju	27 REGISTRAR'S GNATURE					

